FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

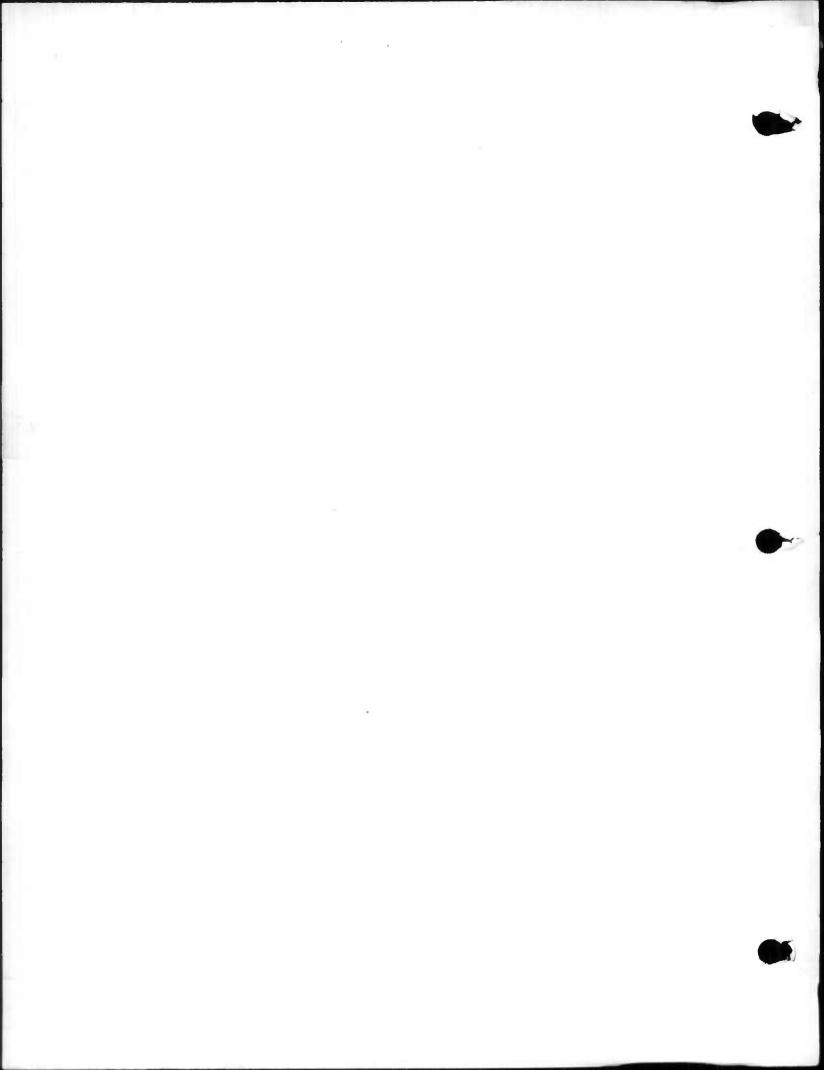
| | REGISTRAR | | CERTIF | ICATE C | F DEATH | | REG. NO. | | | | |
|---------------|------------------------------------------------------------|----------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------|------------------------------------|------------------|-----------------------|----------------|---------------|--------------------------------------|------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | | 3. | TIME OF DE | ATH |
| | William | Emory | | BLA | KE | Aug | | 199 | YEAR | 4:54 | ~ M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| (In yrs. last birthday) | IF UNDER 1 YEA | | s. 7. DATE | OF BIRTH 14 | | | ACE (State or | Formion |
| | 218-16-7379 | 1 XM 2 - F | 71 YRS. | MONTHS DAY | 8 HOURS MIT | ATTOTAL | OF BIRTH H | 995 | Mary] | land | · di digit |
| | 9a. FACILITY NAME (If not institution, give si | treet and number) | | 9b, CITY, TOW | N OR LOCATION OF | - | | | TY OF DEAT | | |
| Œ | Easton Memorial | Hoenital | | East | | DENIII | | Talb | | n | |
| 띩 | RESIDENCE OF DECEDENT | HOSPILAL | | Last | J11 | | | Tall | OL | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | 1 | 10e. CIT | Y, TOWN OR LO | CATION | | | | 10 | d. INSIDE CIT | ΓY |
| ā | Maryland Queen | Annes | Ce | ntrevi | lle | | | | 1 | LIMITS? | ON |
| AL | 10s. STREET AND NUMBER | | | | 10f. ZIP CODE | | | 10a. CITIZ | | T COUNTRY? | |
| ER | 1613 Burrissvill | e Road | | | 21617 | | | USA | 4 | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | N U.S. ARMED | 13. WAS I | DECENDENT OF HIS | PANIC ORIGIN | ? (Specify Ves | | - | American In | llen |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 X NO | If yes | specify Cuban, Ma (ES 2 2 NO Sp | xican, Puarto F | lican, etc.) | | Black, W | American Inc White, atc. Black | , |
| ВУ | 3 Widowed 4 Divorced | | | | ES 2 EFRO Sp | өспу: | | | Specify: | Diack | |
| 입 | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT'S | USUAL OCCUP | ATION | 16b. | KIND OF BUS | INESS/INDL | JSTRY | | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | |
| 4 | 10th | | Truck | Driver | | R | oyden | Powe 1 | 1 | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S | NAME (First, N | | _ | | | |
| BE | Robert Blake | | | | Nann | ie Bay | nard | | | | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Stre | et and Number or Ru | | | . State. Zho (| Code) | | |
| 2 | Marlene Hollis | | | | sville R | | | | | 1617 | |
| | 20s. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Ramo | 20b | PLACE AND DATE | | | DATE | | CATION - C | | | |
| | 1 Buriel 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | oval from State cem | le & Fem | ther place! | | 1 | | | | | |
| | 21. SIGNATURE OF FUNDIAL SERVICE LIC | ENSEE | Te a rem | 22. NAME | AND ADDRESS OF | FACILITY | /95 C | | | 2, Ma. | |
| - 1 | · 10/ 51 | a . | | | ennie Sm | | | | | | |
| | Xoun H. | Murce | | P | O. Box | 1687, | Easton | , Md. | 216 | 501 | |
| ł | 23. PART Lehter the diseases, or cahock, or heart fellure. | complications that caused Liet only one cause on ea | tha deeth. Do r | not enter the | mode of dying, a | uch aa card | lec or reapi | ratory arre | at, | Approxim | |
| | | | | 1 - | | | | | | Onset ar | |
| | disease or condition resulting in death) | VENTRIC | CULAH | 1 FIBF | ILLAT | JON ! | CARD | IAC I | ARREST | 1-100 | MINA |
| | Transiting in deatily | VENTRIC DUE TO COR AS A HYPERT | CONSEQUENCE OF | F): 40 | | , | CV (· · · | , | | ICA | MINOM |
| z | | HYPERT | ENSIV | E AR | TERIOSO | LERO | TIC H | EART | Dis | 13 | EARS |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | F) · / | | | | | | | |
| 3 | cause. Entar UNDERLYING CAUSE (Disease or Injury | HYPI | = RTEI | NS101 |) | | | | | 54 | EAR |
| E | that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | | | | | | | | |
| E | resulting in death) LAST | 1 | | | | | | | | | |
| 0 | PART II. Other algnificant conditions | a contribution to death b | us and accordance in | - 4 | | | | | | | |
| EDICAL | TOBOCCO | ABUSE: | HYPER | CHO C | ring ceuse given | In Pert I. | 24s. WAS AN PERFOR | | | RE AUTOPSY | |
| ă | TO BITCO | TOUSE) | ITYPER | CHULE | STEROL | -Cmin | 1 TES 2 | X NO | | MPLETION OF DEATH? | CAUSE |
| M | | | | | | | | , | 1[| YES 2 | NO |
| ż | DID TOBACCO USE CONTR | LIBUTE TO CAUSE O | F DEATH YE | S NO | ☐ UNCERTA | AIN 🗆 | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | | ne) | | | | | | |
| S | 1 - YES 29X NO | 1 Inputiant 2 KER/Outp | etient 3 🗆 DOA | OTHER: | ome 5 🗆 Residen | ca 6 🗆 Other | (Specify) | | | | |
| = | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c. | INJURY AT | 7 | CRIBE HOW IN | JURY OCCL | JRED | | |
| Β¥ | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, rear) | l liks | | WORK? YES 2 NO | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | — At home, farm, s | treet, factory, o | Mice | 28f. LOCA | TION (Street e | nd Number o | r Rural Routi | e Number, | |
| 핕 | 4 Homicide determined | building, etc. (Spec | туј | | | City o | r Town, State) | | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the heat of my knowl | idea desta | | | | - No. 1 | | | | |
| ₹ | (Check only one) 2 MEDICAL EXAMINER | CIAN: To the best of my knowledge. On the basis of examination | and/or Impetianta | o in my online. | ata and place, and o | due to the caus | e(a) end man | ner as stated | ł. | | |
| 8 | | | - Interest investigation | ii, iii niy opinior | , death occured at | tne time, date i | ind place, and | dua to the | ceuse(e) an | d manner as | stated. |
| 8 | 296. FRANTURE AND TITLE OF CERTIFIER | JAMES D. | mD | | 29c. LICENSE | NUMBER | | 29d. DATE | SIGNED (Mo | onth, Day, Year, |) |
| 2 | 1. Kent | 11 | | | レル | 16 | | 8 | 12 | -19 | 5 |
| | J. Kent Young MI | 207 N.Li | ATH (ITEM 27) (Type, | | `an+ | 4 7 7 - 1 | MD 01 | C17 | | | |
| | | | _ | JL. (| Centrev | ттте, | | 01/ | | | |
| | AUG 1 0 1995 | 32 REGISTRAN'S SIGNA | Markall | | | | | | | | |

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 found of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

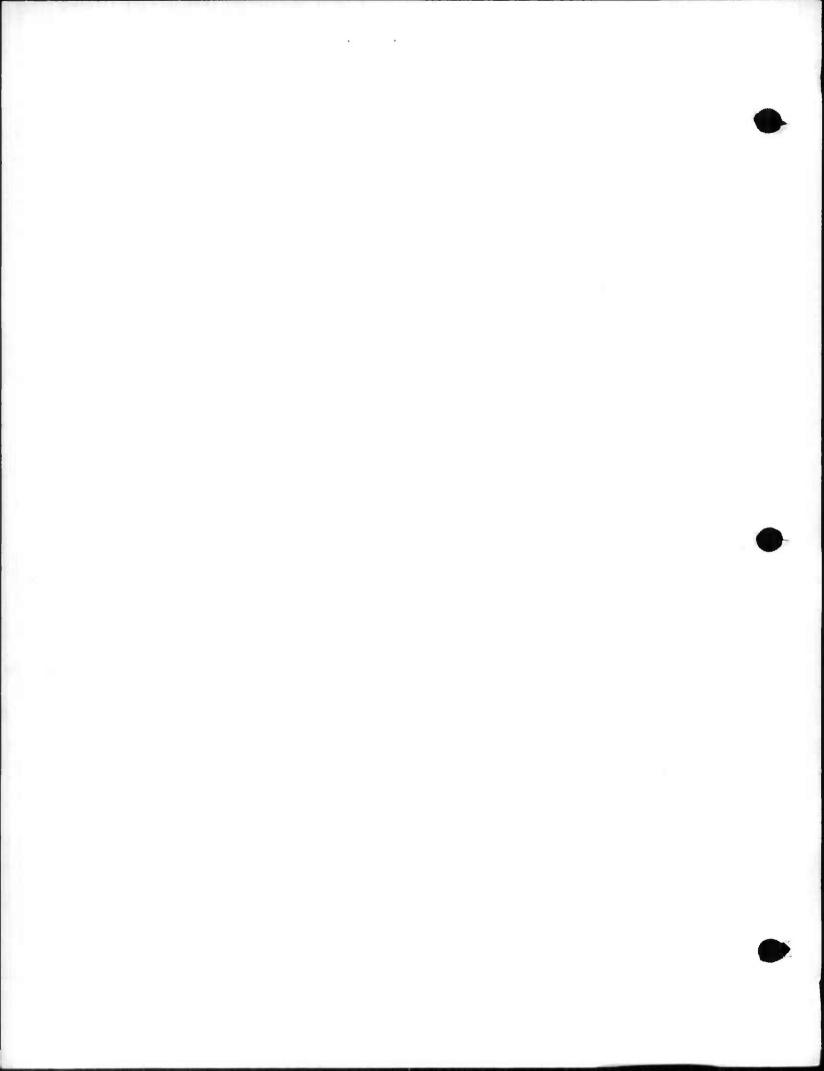


| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 2 | 2 | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | E |
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| | 1 - STATE REGISTRAR | STATE OF I | | | TMENT OF H | | | MENTAL HYGIEI | | | | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | | | | |
| | George Fro | ederick | | Ό | rkhardt , | Tr | | MONTH | DAY | YEAR | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | | | _ | | July 2. | 5 19 | | 10:06 A M | | | | | | |
| | | | 6. AGE (In yrs. lest | ,, | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH | PLACE (State or Foreign | | | | | | |
| | 213-01-8354 | t XM 2 🗆 F | 82 | YRS. | and the same | HOUNS | witte. | JUNE 17 | ,191 | 3 PI | NNSYLVANI | | | | | | |
| | 9a. FACILITY NAME (If not institution, give a | street and number) | | | 9b. CITY, TOWN C | R LOCATI | ON OF DE | | _ | NTY OF D | | | | | | | |
| <u>۳</u> | MEMORIAL HOSP | ITAL | | | EAS | TON | ON TALBOT | | | | | | | | | | |
| Ĕ | RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | |
| Ä | 10e. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWN OR LOCAT | ION | | | | | 10d. INSIDE CITY | | | | | | |
| DIRECTOR | MARYLAND | TALBOT | | | EASTO | N | | | | | t YES 2 NO | | | | | | |
| 7 | 10e. STREET AND NUMBER | | | 101, ZIP CODE | | | | | 10a CIT | ZEN OF W | HAT COUNTRY? | | | | | | |
| FUNERAL | 101 PARK LANE | | 21601 | | | | 0.1 | log. of | US | | | | | | | | |
| N. | 11, MARITAL STATUS | I 40 MMO DECEDEN | | | | | | | | | | | | | | | |
| E | 1 Never Married 2XXMarried | FORCES? 1 | YES 2 N | MED O | 13. WAS DEC | ENDENT C | of HISPAN o. Mexicar | IIC ORIGIN? (Specify Yes or No— 14. RACE — American Black, White, etc.) | | | - American Indian, White, etc. | | | | | | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | | | 1 TES | XXNO | Specify | | - 1 | Specif | y: | | | | | | |
| | | WW I | | | | | | | | | WHITE | | | | | | |
| TE | 15. DECEDENT'S EDU (Specify only highest grade | | (Giv | w kind of v | USUAL OCCUPATION WORK done during most | ON st of worldn | ng . | 16b, KIND OF BU | ISINESS/INC | USTRY | | | | | | | |
| Щ | Elementary/Secondary (0-12) | College (1-4 or 5 |) | Do NOT us | | | | | | | | | | | | | |
| M P | 12 | | ROU | TE | SUPERVI | SOR | | VENDI | NG M | ACH] | NES | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTI | HER'S NAM | ME (First, Middle, Maider | Surname) | | | | | | | | |
| BE (| GEORGE N. F. | BURKHARI | ЭT | | | | AL | ICE STAR | $\mathbf{T}\mathbf{T}$ | | | | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | | | | | | | | | | | | | | | |
| 5 | IRENE M. BURK | HARDT | | | | | | STON, MD | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 □ Burlet 2XX remetion 3 □ Rem | | 20b. PLACE A | ND DATE (| OF DISPOSITION /Ne | me of | | DATE 20c. L | CATION | City or To | en State | | | | | | |
| | 1 Buriet 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | ioval from Stata | | | Y CREMA | | v : | 1 | LISB | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | Dimi | DOIL | | | | | | - | THE | | | | | | |
| | | | | | NEWN | IAM | FUNI | ERAL HOM | E, P | .A. | | | | | | | |
| | JOHN R. | MERCE | RON | cFs | 200 | S. | HARI | RISON ST | ., E | ASTO | N, MD | | | | | | |
| | 23. PART i. Enter the diseeses, or | complications the | caused the dea | th. Do n | ot enter the mo | de of dyl | ng, such | as cardiac or resp | iratory sn | est, | Approximate | | | | | | |
| | snock, or neart salure. List only one ceuse on each line. | | | | | | | | | | | | | | | | |
| | disesse or condition | 1 | 7010 | 7 | 1.80 | _ | 11 | 0_ | | | Onset and Death | | | | | | |
| | resulting in death) | a | 147 | _ | The of a | | ye | won_ | | | SIM IN | | | | | | |
| | | DUE 10 | OR AS A CONSECU | UENCE OF | 7): V | | 0 | | | | 11 | | | | | | |
| Z | Sequentially list conditions, | B. 167 | 47 C | | me | - | 19 | 75 Y | disease or condition resulting in death) a. ASIND E folder amy Chon DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions D. ASIND E folder amy Chon MARS 4 Mo Acd | | | | | | | | |
| Ĕ | if any, leading to immediate | | | | | | | | | | I PIO TEG | | | | | | |
| 8 | cause. Enter UNDERLYING | | | | | | | | | | THIS TEG | | | | | | |
| _ | III CAUSE (Disease or injury | c | | | | | | | | | 710 160 | | | | | | |
| Ĕ | CAUSE (Disease or injury thet initiated events | c. DUE TO | OR AS A CONSEQU | UENCE OF | 7: | | | | | | 7 715 1766 | | | | | | |
| BITIE | | c. DUE TO | OR AS A CONSECU | JENCE OF | 7): | | | | | | 7 715 116 | | | | | | |
| CERTIFICATION | thet initiated events resulting in death) LAST | d | | | | | | | | | 7 715 1120 | | | | | | |
| - 1 | thet initiated events | d | | | |) ceuse g | jiven in I | Part I. 24a. WAS AI | I AUTOPSY | 24b. | WERE AUTOPSY FINDINGS | | | | | | |
| - 1 | thet initiated events resulting in death) LAST | d | | | |) ceuse g | jiven in I | PERFO | I AUTOPSY RMED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | |
| - 1 | thet initiated events resulting in death) LAST | d | | | | l ceuse g | given in I | Part i. 24a. WAS AI PERFO | I AUTOPSY RMED? | 24b. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | |
| - 1 | PART II. Other significent condition | d. | death but npt re | suiting i | n the underlying | | | PERFO | I AUTOPSY RMED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | |
| - 1 | thet initiated events resulting in death) LAST | d. | death but not re | suiting i | n the underlying | | given in I | PERFO | I AUTOPSY RMED? | 24b. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | |
| - 1 | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | RIBUTE TO CA | death but not re USE OF DEAT 26. PLACE | H YE | n the underlying S NO H (Check only one) OTHER: | UNC | ERTAIN | PERFO | I AUTOPSY RMED? | 24b. | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | |
| - 1 | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO | RIBUTE TO CA | USE OF DEAT 26. PLACE ER/Outpetlent 3 | H YE | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home | UNC | ERTAIN | PERFO 1 YES | I AUTOPSY RMED? 2 MO | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | |
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| BY PHYSICIAN: MEDICAL | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be | RIBUTE TO CA HOSPITAL: 1 Inpettent 2/ 28a. DATE OF (Month, Da | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY y, Year) | H YE OF DEAT | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home E OF 28c. INJU | UNC 5 G Re URY AT RK? TES 2 | ERTAIN | PERFO 1 YES 8 Other (Specify) 28d. DESCRIBE HOW 281. LOCATION (Street | I AUTOPSY RMED? NO INJURY OCC | CURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| BY PHYSICIAN: MEDICAL | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 HO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | RIBUTE TO CA HOSPITAL: 1 Inpettent 2/ 28a. DATE OF (Month, Da | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY (), Year) | H YE OF DEAT | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home B OF 28c. INJL URY WO! 1 Y | UNC 5 G Re URY AT RK? TES 2 | ERTAIN | PERFO 1 YES B Other (Specify) 28d. DESCRIBE HOW | I AUTOPSY RMED? NO INJURY OCC | CURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| BY PHYSICIAN: MEDICAL | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined | RIBUTE TO CA HOSPITAL: 1 Inputent 2 26a. DATE OF (Month, Did building.) | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY 19, Year) FINJURY — At homitic. (Specify) | H YE OF DEAT | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home E OF | UNC 5 Re DIRY AT RK? ES 2 | ERTAIN sidence | PERFO 1 YES 8 Other (Specify) 28d. DESCRIBE HOW 281. LOCATION (Street City or Town, State | I AUTOPSY RMED? Z NO INJURY OCC | CURED or Rural A | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| BY PHYSICIAN: MEDICAL | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) CERTIFYING PHYSI | RIBUTE TO CA MOSPITAL: 1 Inpettent 2 28a. DATE OF (Month, Did 26a. PLACE Of building, | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY 19, Year) FINJURY — At homitic. (Specify) | H YE OF DEAT DOA 28b. TIMM No, farm, s | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home E OF | UNC 5 G Re UNY AT RK7 TES 2 | ERTAIN sidence (| PERFO 1 YES 5 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State | I AUTOPSY RMED? 2 NO INJURY OCC and Number | CURED or Rural A | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| PHYSICIAN: MEDICAL | Thet initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | RIBUTE TO CA HOSPITAL: 1 Inpettent 2 28a. DATE OF (Month, Do. 26a. PLACE Of building. CIAN: To the best of a: | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY 19, Year) FINJURY — At homitic. (Specify) | H YE OF DEAT DOA 28b. TIMM No, farm, s | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home E OF | UNC 5 G Re UNY AT RK7 TES 2 | ERTAIN sidence (| PERFO 1 YES 5 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State | I AUTOPSY RMED? 2 NO INJURY OCC and Number | CURED or Rural A | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| E COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) CERTIFYING PHYSI | RIBUTE TO CA HOSPITAL: 1 Inpettent 2 28a. DATE OF (Month, Do. 26a. PLACE Of building. CIAN: To the best of a: | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY 19, Year) FINJURY — At homitic. (Specify) | H YE OF DEAT DOA 28b. TIMM No, farm, s | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home E OF | UNC 5 Re TRES 2 and place, with occurrent | ERTAIN sidence (| PERFO 1 YES 8 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma lime, data and place, and BER | I AUTOPSY RMED? 2 NO INJURY Occ and Number | or Rural R | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| COMPLETED BY PHYSICIAN: MEDICAL | Thet initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | RIBUTE TO CA HOSPITAL: 1 Inpattent 2/ 26a. DATE OF (Month, Di 26a. PLACE Of building. | USE OF DEAT 26. PLACE ER/Outpetlent 3 (INJURY), Year) FINJURY — At homitic. (Specify) my knowledge, deat smination and/or in | H YE OF DEAT DOA DOA 28b. TIMI | n the underlying S NO H (Check only one) OTHER: 4 Nursing Home E OF | UNC 5 Re TRES 2 and place, with occurrent | ERTAIN sidence (NO and due to ad at the to | B Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and ma | I AUTOPSY RMED? 2 NO INJURY Occ and Number | or Rural R | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO oute Number, and manner se stated. | | | | | | |

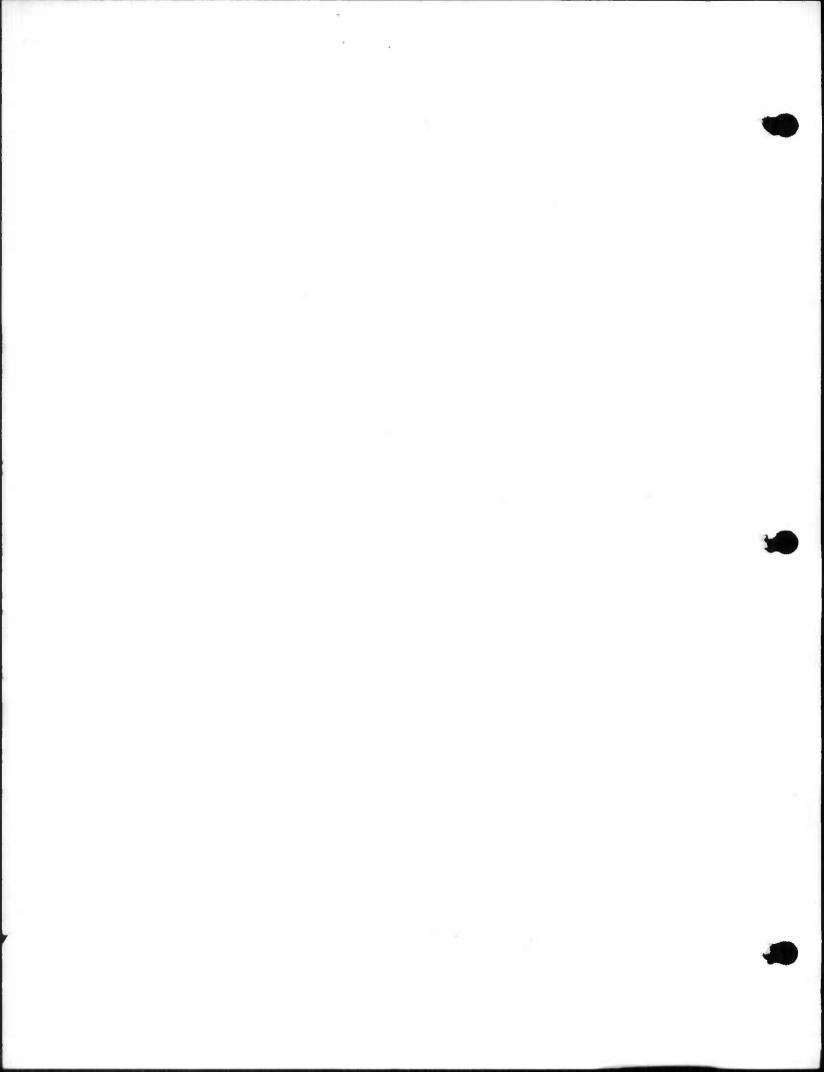
STEPHEN P.
31. DATE FILED (Month, Day, Year)

JUL 27



| ise as the burial-transit permit. Pages 1, 2, 3 should | | | |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| neral director, page 5 should be detached for use as the | | miner must be notified at once. | |
| te has been signed by the attending physician and completely filled in by the funeral director, page 5 sh | Mental Hygiene prior to burial, cremation, or removal. | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifi | |
| IDR: After this certificate has been signed by the | he State Dept. of Health and P | 28 is marked, or item 23 shows any inju | |
| TO THE FUNERAL DIRECT | be filed within 72 hours after death with it | IMPORTANT: If item 28 is marked | |
| | | | |

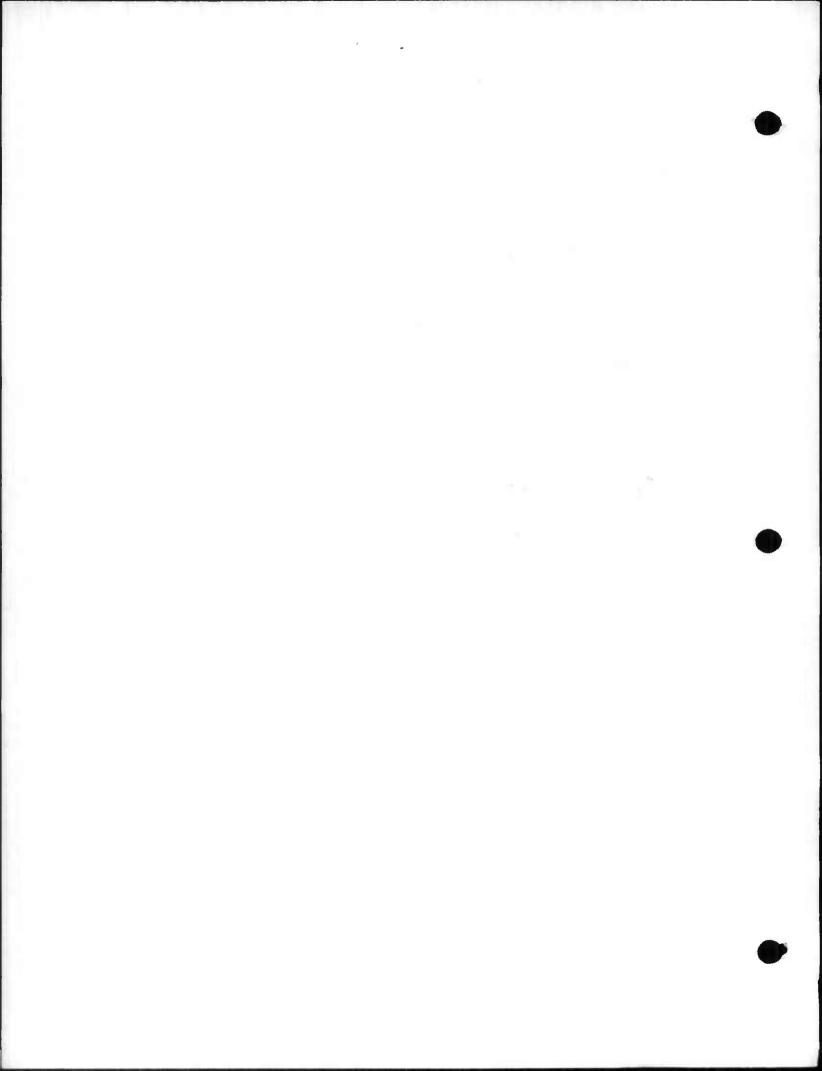
| FOR 1 - STATE REGISTRAR | STATE OF MARYL | | IENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------|--------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Le | Bridge | | unhan | 2. DATE OF DEATH MONTH DAY | YEAR 95 | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER 215-05-1558 90. FACILITY NAME (If not institution, g. | 1 □ M 2 💢 F 82 | YRS. MO | UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN. | | Country | yland | |
| Chesapeake H | ealthcare & Re | ehabiltatio | on Arnold | | Anne Aru | nde l | |
| | ne Arundel | | adena, | | 10g. CITIZEN OF W | 10d. INSIDE CITY LIMITS? 1X YES 2 NO | |
| 10e. STREET AND NUMBER 217 Catalfa Av 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER | IN U.S. ARMED | 21122 | NIC ORIGIN? (Specify Yee o | U.S.A. | American Indian, | |
| 3 XWidowed 4 Divorced | FORCES? 1 TYES | DATES 160. DECEDENT'S US | If yes, specify Cuben, Mexic 1 YES 2 NO Specification | | Specifi | White White | |
| 15. DECEOENT'S (Specify only highest g Elementary/Secondary (0-12) 11 17. FATHER'S NAME (First, Middle, Last) | rade completed) College (1-4 or 5+) | | done during most of working tired.) | Home | NEGS/INDUGTRT | | |
| | | | | AME (First, Middle, Meiden St. Jump | urname) | | |
| R. Austin B 190. INFORMANT'S NAME (Type/Print) Carole A. Water | | | DRESS (Street and Number or Rural | Route Number, City or Town, | | 1122 | |
| 20a. METHOD OF DISPOSITION | 20s. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, other place) | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE | | 0 | 22. NAME AND ADDRESS OF FA Harrison E. Le 312 S. Talbot | eonard Fune | ral Home | | |
| 23. PART I. Enter the diseases, shock, or heart faild iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. ASP | each line. | | ch as cardiac or raspire | | Approximata interval Between Onset and Death | |
| Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST | C | A CONSEQUENCE OF): | | | | | |
| PART II Other significant condi | - IM ERS | but not resulting in to DISCAS | | Part I. 24a. WAS AN A PERFORM 1 YES 2 | IED? | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 The state of | HOSPITAL: 1 □ Inpatient 2 □ ER/Ou | | 28-PLACE OF OEATH (C | | | | |
| 27. MANNER OF DEATH 1 — Natural 5 — Pending 2 — Accident Investigat | | 28b. TIME C | PE 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HOW IN. | JURY OCCURED | | |
| | building, etc. (Sp | RY — At home, farm, streecity) | et, factory, office | 281. LOCATION (Street en City or Town, State) | d Number or Rural R | oute Number, | |
| one) | THE RESERVE OF THE PERSON OF T | | nt the time, date end place, end du in my opinion, death occured at th | | | and manner ee stated. | |
| 296. SIGNATURE AND TITLE OF CERT | Her After | olly | 29c. LICENSE NO | 1776 | ≥ 7/2 | (Month, Day, Year) | |
| 30. NAME AND AGORESS OF PERSON | WHO COMPLETED CAUSE OF D | LGD-O | CRATN HW | suite/0 | 6 GLENE | SURTEMO | |



MORE, MARYLAND 21215-0020

| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should the State Dept. of Heath and Mental Hygiene prior to bunial, cremation, or removal. | medical examiner must be notified at once. |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68/60 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTI | MENT OF H | EALTH AND | MENTAL HYGIEN | | |
|---------------|--------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------|---------------------------|--------------------|-------------------------------------------------|---------------------|-------------------------------------------------|
| | DECEDENT'S NAME (First, Middle, Lest) F | RANCIS FRAN | | BAYN | | 2. DATE OF DEATH JULY 21 | | 3. TIME OF DEATH 6:25 a M |
| | 4. SOCIAL SECURITY NUMBER | | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8, BIF | TTHPLACE (State or Foreign |
| | 218-12-7559 | 1X M 2 🗆 F | / 4 YRS. | | | 03/21/21 | | ryland |
| œ | 9a. FACILITY NAME (If not institution, give at | treet end number) | 9 | b. CITY, TOWN (| OR LOCATION OF D | EATH | 9c. COUNTY OF | DEATH |
| DIRECTOR | Memorial Hospi | tal of East | ton | Eas | ton | | Ta1 | bot |
| E | 10a. STATE 10b. COUNTY | , | 10c. CITY, 1 | TOWN OR LOCAT | TON | | | 10d. INSIDE CITY |
| | Maryland Dor | chester | | Hur | lock | | | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | | F WHAT COUNTRY? |
| FUNERAL | 5103 Harrison | Ferry Road | | | 2 1 | 643 | Unite | d States |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 X YES | U.S. ARMED | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specity Years, Puerto Rican, stc.) | or No- t4. RA | ACE — American Indian, ack, White, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | | | 2 NO Specif | | | ec//y: White |
| | 15. DECEDENT'S EDUC | CATION | 16a. DECEDENT'S US | UAL OCCUPATION | DN . | 165 KIND OF BUS | SINESS/INDUSTRY | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of world life. Do NOT use n | k done during ma | st of working | TOU. KIND OF BOX | JINESS/INDUSTAT | |
| 린 | 12th | | Mechan | ic | | Cannin | g Fact | ories |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | |
| BE | | John Baynaı | c d | | Land | a Hughes | | |
| စ္ | 19a. INFORMANT'S NAME (Type/Print) | 2 | 19b. MAILING AC | DRESS (Street a | nd Number or Rural | Route Number, City or Town | n, State, Zip Code) | |
| - | Elsie Foote Ba | | | | | ry Rd., | Hurloc | k, MD21643 |
| | 20a. METHOD OF DISPOSITION 1 I Burial 2 □ Cremetion 3 □ Remo | oval trom State 20b. | PLACE AND DATE OF to | DISPOSITION (Na place) | me of | 1 | CATION — City or | |
| | 4 Donation 5 Other (Specify) | | astern S | | Veteran | s 24 Hu | rlock, | Maryland |
| | -M. 1: 01 | E long | | | | | ow Fun | eral Home |
| | Michay | Corean | | PO Bo | x 43, F | ederalsb | urg, M | D 21632 |
| | 23. PART I. Enter the diseases, or c ehock, or heart fellure. I | omplications that caused List only one ceuse on ee | the deeth. Do not ch line. | enter the mo | de of dylng, suc | h as cardiac or respi | ratory screat, | Approximata Interval Between |
| | iMMEDIATE CAUSE (Finei disesse or condition | Caroli. | 2 | 7 | | 7 | | Onset and Death |
| | resulting in desth) | DUE TO (OR AS A | CONSEQUENCE OF) | non | on a | new | 1 | |
| z | Sequentially list conditions. 6. 5/3 Such total gartientoring for 2 days | | | | | | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | , | | 7 | 1 | |
| 2 | CAUSE (Disease or injury | corcing | CONSEQUENCE OF): | al | The | - losur | ch | |
| | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSCOUENCE OF): | | | | | |
| 8 | | 1 | | | | | | |
| Ŋ. | PART II. Other aignificent conditions | s contributing to death bu | t not resulting in t | the underlying | ceuse given in | Part I. 24s. WAS AN. PERFOR | | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| 5 | | | | | | 1 [] YES 2 | No | COMPLETION OF CAUSE OF DEATH? |
| × | DID 703 1 440 1141 401 1141 | | | | | | | 1 TYES 2 NO |
| CIAN: MEDIC | DID TOBACCO USE CONTR | | | | UNCERTAI | N [2] | | |
| SIC | EXAMINER? | HOSPITAL: | | THER: | | | | |
| PHYS | 27. MANNER OF DEATH | 1 ☑ Inpetient 2 ☐ ER/Outpe | 18b. TIME O | | | 8 Other (Specify) | LUIDU GOOLIGE | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJUR | Y WO | RK7 | 28d. DESCRIBE HOW IN | SURY OCCURED | |
| D B√ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | - At home, farm, stree | | | 281. LOCATION (Street a | nd Number or Burn | I Boute Number |
| w II | 4 Homicide determined | building, etc. (Specif | y) | | | City or Town, State) | | |
| COMPLET | 298. CERTIFIER 1 CERTIFYING PHYSIC | IAN: To the best of my knowle | dge, death occurred a | t the time, date | and place, and due | to the cause(s) and man | ner en steled | |
| N N | | 3: On the basis of examination | | | | | | e(a) end menner ee stated. |
| Ŭ | 296 BIOMATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | | | ED (Month, Day, Year) |
| | Jul 1848 | | 10 | | D23066 | | D7/2 | 1/95 |
| ĭ | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | / - | . / [3 |
| | Stanley Bysshe | | | 's La | ne, Eas | ton, MD | 21601 | |
| | 31. DATE FILED (Month, Day, Year) | 32, REGISTRAR'S SIGNA | Whe fall | | | | | |
| - 1 | JUL 26 1995 | (Your bonne | | | | | | - 1 |



REG. NO

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH RICHARD BRANCH AUGUST 18 1995 9:50AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) * BARTHPLACE (Sint of Forward to n Country) Charleston 1942 West Virgini IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 × M 2 🗆 I HOURS MIN. 579-84-1979 53 YRS Jan Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince Georges Hospital Center DIRECTOR Chever1v Prince Georges 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince Georges Md. Seat Pleasant 1 X YES 2 NO permit. 10e, STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. 6309 Greig St. 20743 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf was apacify Cuban, Maxican, Puerto Rican, etc.) 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Ri
1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Black ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) COMPL 12 Handicapped _ _ 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname William Branch notified at BE Opal Bundrant 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Opal Mundy 6309 Greig St. Seat Pleasant, Md. 20743 pe 20e. METHOD OF DISPOSITION

1 N Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must funeral director, Cedar Hill ■ □ Donation 5 □ Other (Specify) Cemetery 8-23-95 Suitland, Md. 21. SIGNATURE OF FUNERAL SERVICE, AICENSE medical examiner 22. NAME AND ADDRESS OF FACILITY Capitol Mortuary death. 1425 Maryland Ave., NE Wash., DC yscian and completely filted in by the prior to burial, cramation, or remost. 23. PART I. Enter the disey complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail val Betwe IMMEDIATE CAUSE (Final Onset and Death 朝 disease or condition_ and hice resulting in death) event. DUE TO JOH AS A CONSEQUENCE OF traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the attending physician Mental Hygene prior to to cause. Enter UNDERLYING CAUSE (Disease or Injury offher 1 that initiated events DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST b Injury. PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO A P Sill, Keld Aleesee signe | Health COMPLETION OF CAUSE 1 - YES 2 NO shows : has been s Dept. of H 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES NO 10 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked. Natural Pending М 1 YES 2 NO BY After death 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 3 Suicide 60 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d 8 Could not be 4 Homicide 200 determined Ħ hours item COMPL 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE FUNERAL ID FINE MINING 72 H (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.SIMER JOBWINDER 7525 Eleman 20270 31. DATE FILED (Month, AUG 32 AUGUSTR D'S SIGNATUR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

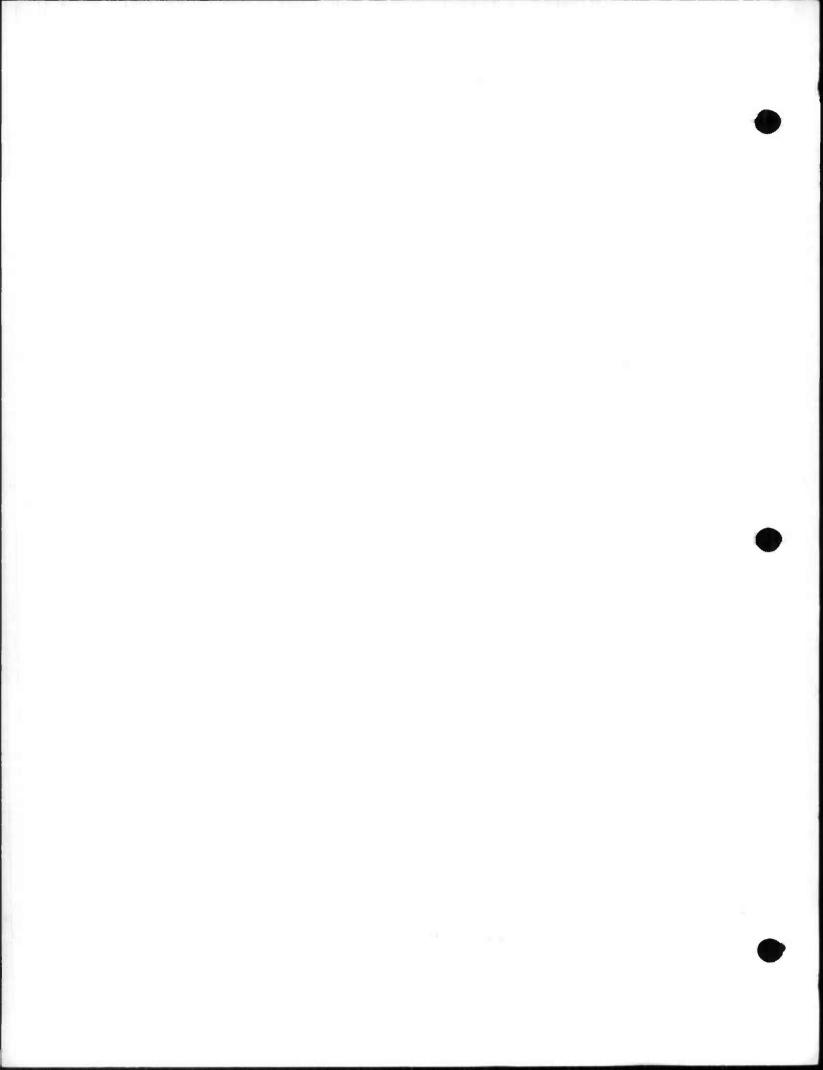
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1. DECEDENT'S NAME (First, Middle, Last, JOHN | | EUGENE | | | BR | YANT | MONT | ог DEATH В | | YEAR | 3. TIME OF DEATH 2:30AM |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Id | ast birthday) | IF UNDER 1.1 | - | IF UNDER 24 HRS. | | OF BIRTH | 7.5 | a BigTi | IPLACE (State or Forei |
| | 496-28-8311 | 1 🕅 M 2 🗆 F | 65 | | MONTHS C | | OURS MIN. | (Monti | , Day, Year) | | Counti | ' Y') |
| | 9a. FACILITY NAME (If not institution, give | | 0.5 | | AL DITH T | | | | 4, 1 | | | ington, |
| œ | | | | | | | LOCATION OF D | EATH | | 9c. COUN | VTY OF D | EATH |
| 2 | PHYSICIANS MEMOR | <u>LAL HOSPITAL</u> | | | LAPLATA | | | | CHARLES | | | |
| 8 | 10a. STATE 10b. COUNT | TY | | 10c. CITY. | ITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY | | | |
| DIRECTOR | Maryland Prin | ce George | 1.0 | | pital Heights | | | | | LIMITS? | | |
| AL | 10s. STREET AND NUMBER | ce deorge | 5 | Cap | ILai | | IP CODE | | - | 1 YES 2 X NO | | |
| A | | | | | | | | | | | | |
| FUNER | 4220 Will Street | | | | | | 0743 | | | United States | | |
| 2 | 1 Never Married 2 Married | | X YES 2 | NO | 13. WA | S DECEN | DENT OF HISPA | NIC ORIGIN | ? (Specify Yes lican, etc.) | es or No— 14. RACE — American Indian, Black, White, atc. | | |
| A | 3 Wildowed 4 Divorced | 1948 to | AR OR DATES | | 1 [| YES 2 | NO Speci | ly: | | | Speci | |
| 0 | 15. DECEDENT'S ED | | | | | | | | | | | White |
| | (Specify only highest gree | | (1 | ECEDENT'S U Give kind of wo e. Do NOT use | ork done dun | ing most o | of working | 16b. | KIND OF BU | SINESS/IND | USTRY | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5 +) |) | | | | | | | | | |
| COMPLET | 12 | | Co | nstru | ction | | | | nstru | | Uni | on |
| _ | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Malden Surname) | | | | | | | |
| BE | George Bryant | | Mary Frances | | | | | | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | . 1 | | | | | Number or Rural | | | | | |
| | James N. McConke | У | | 13394 | Beac | h Ha | aven Ci | rcle, | Newbu | irg, | Mary | land 20 |
| | 20a. METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Ref | norm State | | ANDDATEO | | ON (Neme | of | OATI | 20c. LO | CATION — C | City or To | wn, State |
| | 4 Donation 6 Other (Specify) Fort Lincoln Cemetery 8/23/95 | | | | | | | | Brei | twoo | d. M | [aryland |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | | | 22. NA | ME AND | ADDRESS OF FA | CILITY | | | | aryrand |
| 21. SIGNATURE OF FUNEBAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FOR Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the disease or condition resulting in death) 25. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the disease or condition resulting in death) 26. Due to (or as a consequence of): 27. Due to (or as a consequence of): 28. Due to (or as a consequence of): 29. Due to (or as a consequence of): 21. Due to (or as a consequence of): 22. Name and address or facility Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the conditions of the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, in the ca | | | | | | | | | | | | |
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| DING PHYSICIAN: The law requires that the death certificate be executed with N ze hours after death. Page 6 may be retained by the hospital or attending physician. | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 | death with the State Dept. of Health and Mental Hygi | s marked, or item 23 shows any injury, or of |
| TENDING PHYSICIAN: The law requires that the death ce | IDR: After this certificate has been signed by the attending | ifter death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | 18 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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asp 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OFATH BERKE **ABRAHAM** 16 1995 AÜĞÜST 12:15 A M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. MAY 15 1979 DAYS HOURS MIN. 1 M 2 F 16 215-33-7506 ERITREA Sa. FACILITY NAME (If not institution, give street and number, 96. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK MONTGOMERY 112 RITCHIE AVE DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO MONTGOMERY SILVER SPRING FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20904 **ERITREA** 112 RITCHIE AVENUE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced BLACK COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) NONE STUDENT 11TH 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) ISEGE TEKESTE AMBRAHAM BERHE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8402 POTOMAC VALLEY COURT, FT. WASHINGTON, MD 20744 ESTEFANOS MESMER 20s. METHOD OF DISPOSITION
1 | 文Burisi 2 | Cremation 3 | Removal from State OATE 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of AUG 19/95 WASHINGTON, D.C. GLENWOOD CEMETERY 4 Donation 5 Other (Specify) W.H. BACON FUNERAL HOME INC. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 3447 14TH STREET, N.W. WASHINGTON, D.C. 20010 276 23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Batween Onset and Death IMMEDIATE CAUSE (Finei disesse or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate

| PART II. Other aignificant condition | e contributing to death but not | resulting in the u | ndarlying cause given in | Part i. | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY PINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
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| 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation | 28s. DATE OF PUURY Fo(Month, Opy, Year) | 26b. TIME OF INJURY 12 15 AM | 28c, INJURY AT WORK? 1 YES 2 NO | 5u | rescribe how injury occured to be eff | | |
| 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | CKTION (Street and Numer Party North Nag | | |

mination and/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(a) end menner as stated. AUGUST 16,1995 29b. SIONATURE AND TITLE OF GERTIFIED 29c. LICENSE NUMBER

O.C.M.E

COMPLETED ALISE OF OEATH (TEM 17) (Penn Street, Baltimore, M 21201

A NEG TRANS SIGN TUDE

The state of the s

OF VITAL RECORDS, P.O. BOX 68760 DIVISION

HOSPITAL DR ATTENDIN

TO THE HOSPITAL DR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2

PHYSICIAN: MEDICAL

COMPLETED BY

BE

2

| | OFFICTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
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| | ermit. Pages | |
| nysician. | urial-transit pe | |
| attending ph | use as the bu | |
| ne hospital or | detached for | once. |
| etained by th | should be | otified at |
| е 6 тау ре | rector, page | must be n |
| or death. Pag | he funeral di | examiner |
| 24 hours after | filled in by the | he medical |
| cuted within | d completely wrial, cremat | tlc event, 1 |
| ificate be exe | physician ar | her trauma |
| he death cert | the attending Mental Hygie | njury, or of |
| equires that 1 | en signed by of Health and | hows any I |
| AN: The law r | ficate has be State Dept. | r Item 23 s |
| DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending | . DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| DR ATTEND | DIRECTOR:) | Item 28 Is |

resulting in death) LAST

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 4:15 P. AUG. 23, BAKER FRANCES 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 37 Sept. 18, 1957 North Carolina 1 M 2 XF YRS 218-78-5765 9c. COUNTY OF DEATH 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR WESTMINSTER RANDOM HOUSE CO CARROLL CO. 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE New Windsor Carroll 1 YES 2 X NO Maryland FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 100. STREET AND NUMBER U.S.A. 21776 1916 Old New Windsor Rd. t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indien, Black, White, etc. 11. MARITAL STATUS Specify: White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR OATES 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Distribution Center Fork Lift Operator 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Mary Esther Farlow Thomas Gary Hallman Sr. BE 19a. INFORMANT'S NAME (Type/Print) b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21776 1916 Old New Windsor Rd. New Windsor, Md. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Steven Wayne Baker 20a. METHOD OF DISPOSITION
1

Surial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Mt. Pleasant Cemetery 8/26 Gamber, Md. 4 Donation 8 Other (Specify) 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Fletcher Funeral Home 254 E. Main Street, Westminster, Md. 23. PART i. Enter the placesee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or week fellure. List only one cause on each line. Interval Batween Onset and Desth IMMEDIATE CAUSE (Final disease or condition resulting in deeth) In wies S A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events

| PART II. Other eignificent condition | e contributing to death but not reet | ulting in the underlying cause given | in Pert I. | 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 \(\square\) NO |
|----------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------|------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------|
| DID TOBACCO USE CONTI | RIBUTE TO CAUSE OF DEATH | YES NO UNCERTA | AIN 🔲 | | C \ |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? t XYES 2 NO | 26. PLACE C HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 | OF OEATH (Check only one) OTHER: DOA 4 □ Nursing Home 5 □ Residence | ca 8 [VOth | er (Specify) JOB | |
| 27, MANNER OF DEATH 1 Natural 5 Pending 202 Accident Investigation | 28a. OATE OF INJURY (Month, Day, Year) Found \$123/95 | 8b. TIME OF 100 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DE | SCRIBE HOW INJURY OCCU | Mon deceased |
| 3 Suicide 8 Could not be determined | 28a. PLACE OF INJURY — At home building, etc. (Specify) | form, street, tectory, office | | CATION (freed and Number of or Town, State) | clary in Westman |
| one) | | occurred at the time, data and place, and estigation, in my opinion, death occured at | | | 7 (|

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE AND TITLE OF CENTIFIER

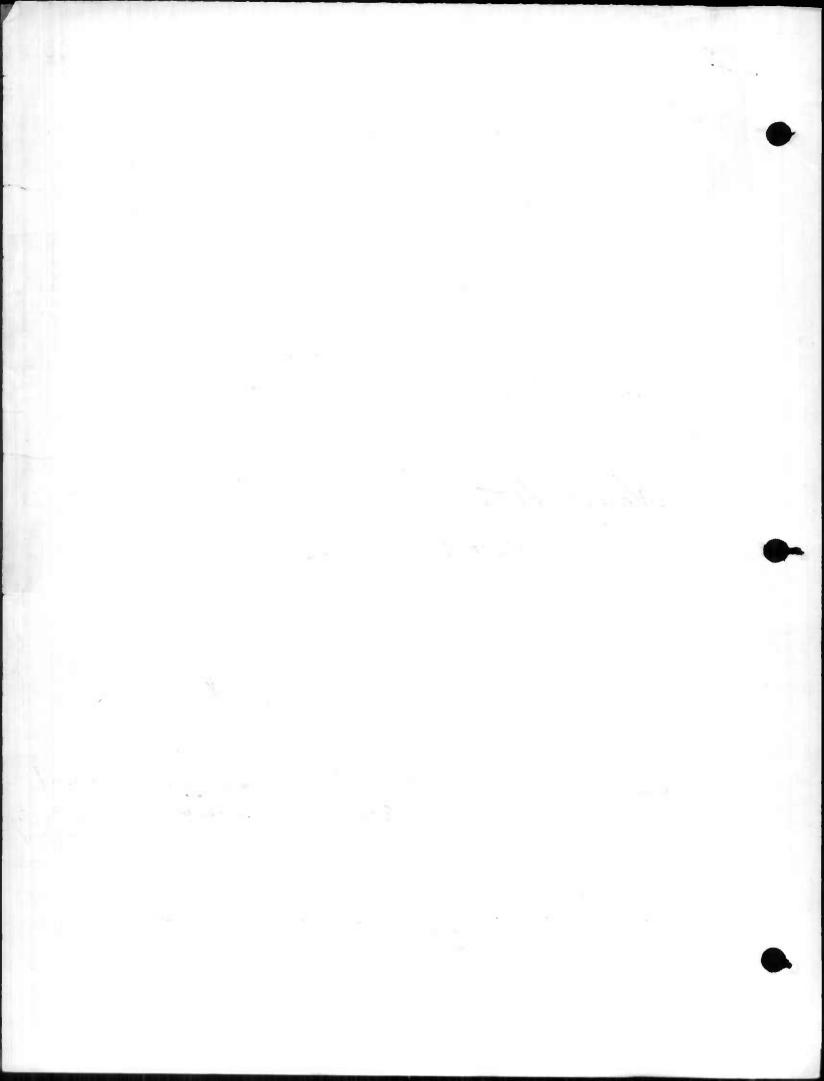
-9 no WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HENORE

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

31 Willist BAR'S EIGNATURE 31. DATE FILED (Month, Day, Year) AUG 2 8 1995

▶AUG. 24,1995

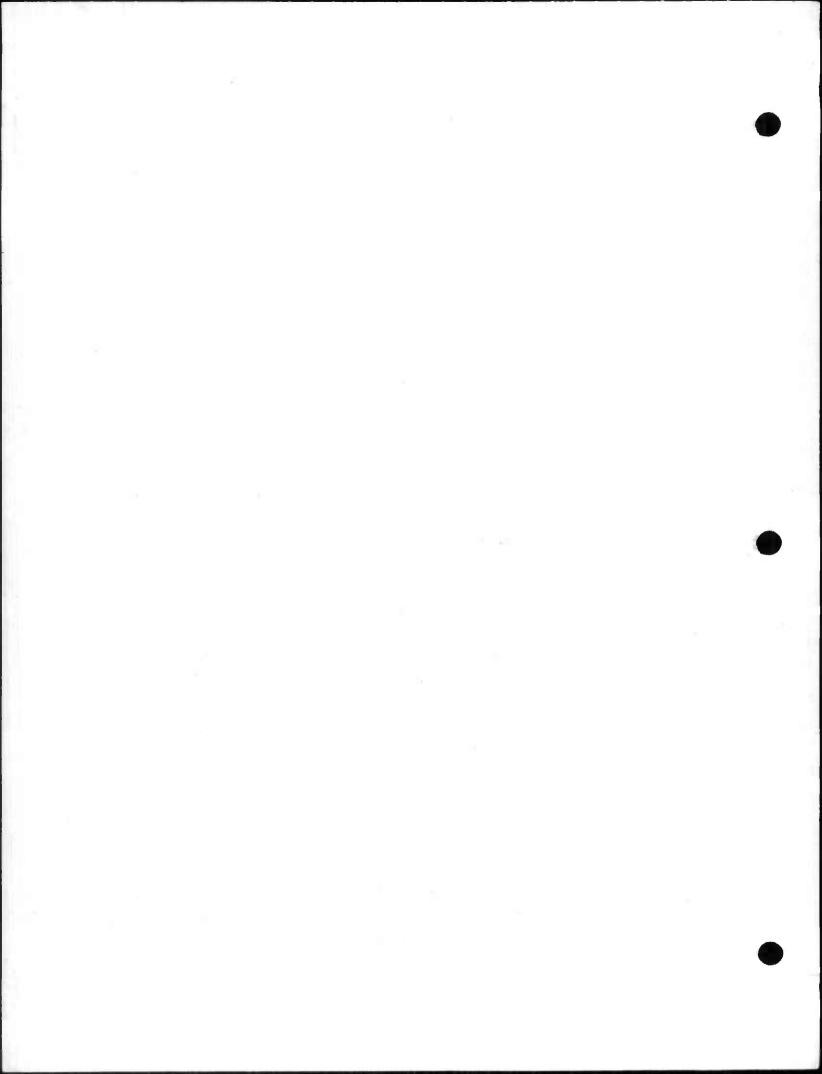


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| | ۲. | C. 1 | 2. 10 | 2.100 | 2.1005 |

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | R | EG. NO. | | | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------|------------------------------|-----------------------------|--------------------------------------|-----------------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF C | EATH | | 3. TIME OF DEATH | | | |
| | Philip Joseph Broha | wn Sr | | | | Angust | 29, 3 | 1995 | 7:30 A M | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | s. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | HRTH | 0. BIRT | NPLACE (State or Foreign | | | |
| | 217-26-7214 1 M 2 9e. FACILITY NAME (If not institution, give street end nur | 1 0 | 0 YRS. | MONTHS DAYS | HOURS MIN. | | 6, 191 | 5 Ma | ryland | | | |
| Œ | Frederick Memorial Hos | | | | OR LOCATION OF D | EATN | | COUNTY OF | | | | |
| 5 | RESIDENCE OF DECEDENT | prear | | Frede | rick | | 1 | reder: | lck | | | |
| DIRECTOR | Maryland Frederic | k | | fferson | | - | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| 7 | 10e. STREET AND NUMBER | | | | Of. ZIP CODE | | 104 | . CITIZEN OF | WHAT COUNTRY? | | | |
| FUNERAL | 3677 Mar-Lu-Ridge Roa | | | 21755 | | | U.S. | | | | | |
| BY FU | 11. MARITAL STATUS | DECEDENT EVER IN U.S ES? 1. DEVES 2 B, GIVE WAR OR DATES WWIT | R IN U.S. ARMED ES 2 NO I DATES 13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Mexic 1 YES 2 NO Specifications | | | an, Puerto Ricen | | o 14. RAC Blac Spe | E — American Indian, ck, White, etc. city: White | | | |
| | 15. DECEDENT'S EDUCATION | | . DECEDENT'S | USUAL OCCUPAT | ION | 18b. KIN | D OF BUSINES | S/INDUSTRY | MILLE | | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (| 1-4 or 5+) | We. Do NOT us | | | | | | | | | |
| ME | 17. FATHER'S NAME (First, Middle, Last) | als E. | xec. D | ir. Con | | No | | | | | | |
| 8 | Elmer Morris Brohawn | | | | 18. MOTHER'S NA | | | ome) | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 105 MAN 1010 | ADDOCAG (0) | | ette M | | | | | | |
| 2 | Dorris R. Brohawn | | | | end Number or Rural Ridge Jef | | , | | 1755 | | | |
| | 20e. METHOD OF DISPOSITION | 20h PL/ | | OF DISPOSITION // | | DATE | | N — City or 1 | | | | |
| -)) | 1 (3) Buriel 2 Cremetion 3 Removal from 9 | State cemeters | cremetory or o | ther place! | al Garden | | | | Maryland | | | |
| | 21. SIGNATURE OF EUNERAL SERVICE LIGHNSEE | 20 1 | enaven | 22. NAME | AND ADDRESS OF FA | CILITY | | | | | | |
| | (Toket Who | Would | 7 | | | | | | HOMES, P.A., MD 21701 | | | |
| | 23. PART I. Enter the diseases, or complication shock, or heart fellure. List only of | oris that saused the | e deeth. Do r | ot enter the m | ode of dying, aud | h as cardiac | or reapireto | V arrest. | Approximate | | | |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | PLE TO (OR AS A CO) | Ine. I V. C. INSEQUENCE OF | saz | coma | (nia | lign | mcy | Interval Between Onset and Death | | | |
| CATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury Interval Between Onset and Death SAZLONIC FINE TO (OR AS A CONSEQUENCE OF): ABOUR MCLIPILE OF THE CONSEQUENCE OF): ABOUR MCLIPILE OF THE CONSEQUENCE OF): C. C. CONSEQUENCE OF THE CONSEQUENC | | | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO (OR AS A COR | NSEQUENCE OF | F): | | | | | | | | |
| DICAL | PART II. Other algnificant conditions contribu | | | - | | Part I. 24a. | WAS AN AUTO | | b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO | | | |
| ш | corevery Que | case | 100 | el st | rote | 10 | YES 2 (1) | 6 | COMPLETION OF CAUSE OF DEATH? | | | |
| PHYSICIAN: M | DID TOBACCO USE CONTRIBUTE T | O CAUSE OF D | EATH YE | S NO [| UNCERTAI | N 🗆 | | | 1 TES 2 NO | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | LACE OF DEAT | N (Check only one |) | | | | | | | |
| YSI | 1 YES 2 NO 1 mpet | ent 2 ER/Outpetien | n 3 □ DOA | OTHER: 4 Nursing Ho | me 5 🗆 Residence | 6 Other (Spe | octfy) | | | | | |
| PH | | DATE OF INJURY (Month, Day, Year) | 28b. TIM | | JURY AT ORK? | 28d. DESCRIB | E NOW INJUR | Y OCCURED | | | | |
| B | 2 Accident Investigation | | | | YES 2 NO | | | | | | | |
| COMPLETED | 3 Suicide 8 Could not be determined | PLACE OF INJURY — A building, etc. (Specify) | it home, ferm, a | street, lactory, offi | ce | 28t. LOCATION City or Tox | (Street and N vn, Stele) | umber or Rural | Route Number, | | | |
| ן ב | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the | best of my knowledge | . death occurre | ed at the time, dat | e and place, and due | In the course(s) | and manner | a stated | | | | |
| S | one) 2 MEDICAL EXAMINER: On the bo | | | | | | | | s) end manner ee stated. | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | | | | D (Month, Day, Year) | | | |
| 8 | Nichaisa a. | -17 210 | | | LUN BIOLINGE NUI | | 200 | CA STUNE | 210 /11 - | | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO COMPLET | ED CAUSE OF DEATH | (ITEM 27) (Type. | Print | 1 | | | 01 | 20/97 | | | |
| | | | | | | | | , | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. RI | EGISTRAR'S SIGNATUR | E . | \ | | | | | | | | |
| | SEP 0 1 1995 S | SUA DANGE | Market | | | | | | | | | |

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| | | REGISTRAR 1. DECEDENT'S NAME (First, Middle, L | net) Naomi BR | | CERTII | FICAI | E OF | DEA | ГН | REG. NO | N 1001 | YEAR | 3. TIME OF DEATN |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------|-------------------------------------------------------|-----------------------------------|-----------------------|---------------------|------------|----------------------------------------------------|-----------------------|-----------|---------------------------------------------------------------------------------|
| | | 4. SOCIAL SECURITY NUMBER | 5, SEX | | Maria Sana | | | т | | August 29 | | _ | 5:16 PM M |
| _ | 1 | 216-14-6901 | 1 M 2 XF | 72 | (In yrs. last birthday YRS. | MONTHS | DAYS | HOURS | MIN, | March 23, 19 | 23 | Country) | LACE (State or Foreign |
| pinous | | 9a. FACILITY NAME (If not institution, g | | | | 9b. CIT | Y, TOWN | DR LOCATI | ON OF DE | | 9c. COUNT | | |
| 2, 3 | СТОВ | Frederick Memo | orial Hospi | tal | | | Fre | deri | ck | | Free | deri | ck |
| t. Pages 1, | DIREC | 10a. STATE 10b. CO | | | | rede | on Loca rick | FION | | | | | 10d. INSIDE CITY LIMITS? 1 YES XX NO |
| nsit permit. | ERAL | 100. STREET AND NUMBER 9719 Masser F | Road | | | 101. ZIP CODE 10g. CITIZEN 0 U.S. | | | | | | | AAT COUNTRY? |
| r attending physician. use as the burial-transit p | BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | | | 13 | If yes, sp | | n, Mexica | IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | or No— 1 | | American Indian, White, atc. |
| o po | BE COMPLETED | 15. DECEOENT'S (Specify only highest (Elementary/Secondary (0-12) | | +) | 16a. DECEDENT (Give kind o life. Do NOT Tech | work done use retired. | during me | ON ost of workli | ng | Biolog: | arch | | |
| by the | | 17. FATNER'S NAME (First, Middle, Last Newton |) | KI | EFAUVER | | | 16. MOTA | HER'S NA | ME (First, Middle, Melden e Mae CR | Sumama) OUSE | | |
| be retained ge 5 should e notified | TO B | 190. INFORMANT'S NAME (Type/Print) Mrs. Mary Brigh | ntwell | | 19b. MAILIN 1041 | 5 Ol | d Na | tiona | or Aural I | ike, Ijams | ville | , Md | . 21754 |
| age 6 may be director, page or must be | | 20a, METNOD OF DISPOSITION 1, Buriel 2 Cremetion 3 1 4 Donation S Other (Specify) | Removal from State | | b. PLACE AND DATI PLOTE VIEW OF VOICE | | | | teribe | 0ATE 20c. LO r 1,1995 Fre | cation — ci ederic | | n, State Maryland |
| hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be a | 100 | 21. SIGNATURE OF FUNERAL SERVICE | E LICENSEE | / | MOO255 | | Keen | | nd Ba | asford P.A rch St. F | | | |
| n certificate be executed within 5x ho ending physician and completely filled Hyplene prior to burial, cremation, or or other traumatic event, the m | CERTIFICATION | disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| ne law requires that the deat has been signed by the atte Dept. of Health and Mental n 23 shows any injury, | SICIAN: MEDICAL CE | PART II. Other algnificant conditions of the part of t | Mell.ty Lysys NTRIBUTE TO CA | 5, | Hypor | 4 Yosi ES [] | NO.E | - (| ERTAIN | PERFOR 1 YES 2 | MED? | 0 | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| PHYSICIAN: The this certificate with the State rked, or item | PHYSIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Netural 5 Pending | HOSPITAL: 1 Inputiant 2 | INJURY | 26b. TI | | raing Hom 28c. INJ | | sidence | 6 Other (Specify) 28d. DESCRIBE NOW IF | URY OCCU | RED | |
| After death | ED BY | V Natural 5 Pending 2 Accident 3 Suicide 6 Could not 4 Nomicide determine | be 26a, PLACE O | F INJURY atc. (Spec | Y — At home, ferm, | M street, fa | 1 🔲 Y | | NO | 281. LOCATION (Street a City or Town, State) | nd Number or | Rural Ro | ute Number, |
| AL DIRI | OMPLET | | NYSICIAN: To the best of at | | | | | | | | | | and menner as stated. |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | D BE CO | 29b. SIGNATURE AND TITLE OF CENT | | 1 | 10 | 0 | - n. | 29c. LICE | 6428 | IBER | 29d, DATE 5 | SIGNED (A | Month, Day, Year) 30, 1995 |
| | 10 | Dr. casper E. C | line III M | D 30 | 00 West 1 | Vintl | n Str | eet, | Fre | ederick, Ma | | | |
| | | 31. DATE FILEO (Month, Day, Year) | 32. APGYSTRA | A'S SIGN | LON RONGE | | | | | | | | |



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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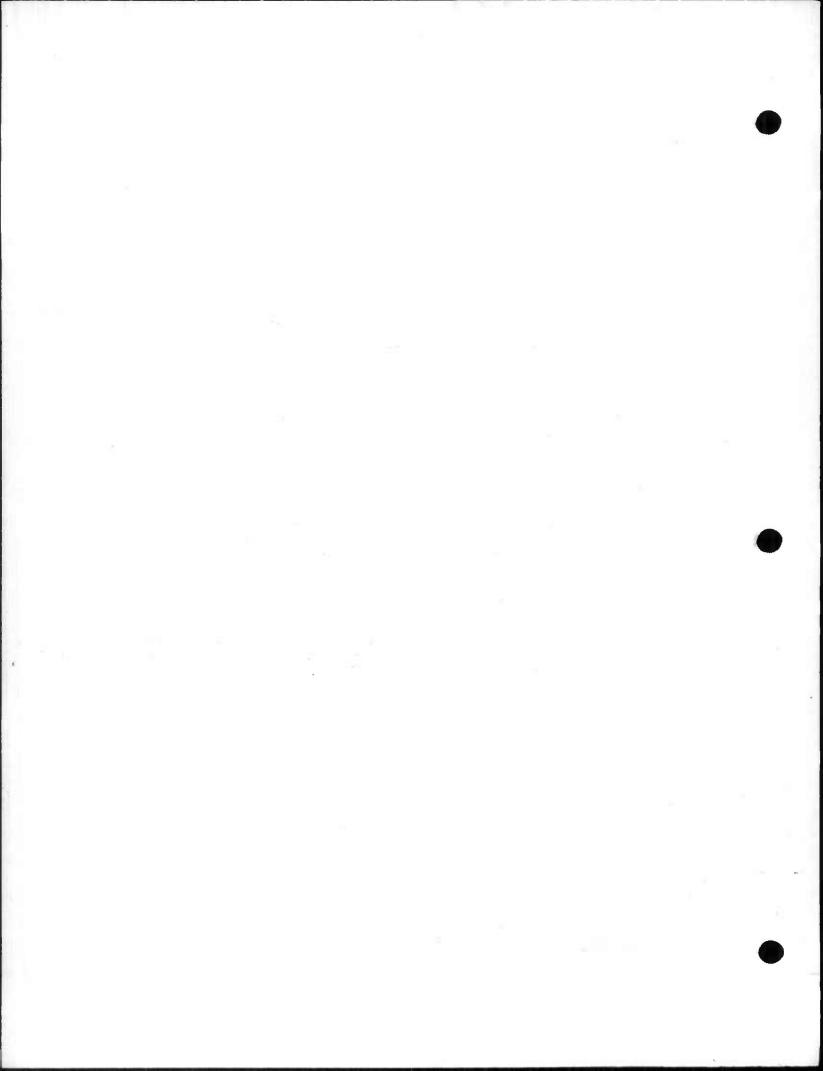
| | | | | | | | | 9 |) (| 10 | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------|--------------|--------------------|---------------------------------------------------|---------------------------------------------------|--------------------------------------|---------------|---------------------------------|---------------------------------------------|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / | DEPAR | TMENT | OF H | EALTH AND DEATH | MENTAL HYGIE | | | | |
| | t. DECEDENT'S NAME (First, Middle, Lest) | | | | | | 2. DATE OF DEATH | | | 3. TIME C | OF DEATH |
| | | Mary Ellen | BIT | LER | | | August 2 | 22, 19 | 995 | 10:0 | 00 A. M |
| | 220_16 2012 | 5. SEX 6. AGE (In yrs. lest 1 \(\triangle M \) 2 \(\triangle N \) F 71 | YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH J. (Month, Day, Year) January 9, | | 8. BIRTH | ylane | ate or Foreign |
| ron | 99. FACILITY NAME (If not institution, give street 10817 Old National RESIDENCE OF DECEMENT | | | | Mar | ket | DEATH | eath sc. county of de Freder: | | | |
| DIRECTOR | 100. STATE 100. COUNTY Maryland Frede | rick | | v, town o | | | | | | 10d. INSI | DE CITY TS? |
| FUNERAL | 100. STREET AND NUMBER 10817 Old Nation | nal Pike | | | | 21774 | | 10g. CITIZEN OF WHAT COUNT U.S.A. | | | |
| BY | 11. MARITAL STATUS t Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARN FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | MED O | 1 11 | t yes, spe | ENDENT OF HISP Holly Cuben, Mexic 2 NO Spec | ANIC ORIGIN? (Specify can, Puerto Ricen, stc.) | fes or No- | Black, | - Americ , white, et Whit | |
| 8 | 15. DECEDENT'S EDUCA | | CEDENT'S | USUAL OC | CUPATIO | N | 16b, KIND OF E | USINESS/IN | DUSTRY | | |
| COMPLETED | (Specify only highest grade co | College (1-4 or 5 +) | ve kind of w Do NOT use Homen | e retired.) | | st of working | | n Hom | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) Frank | TRAC | CEY | | | 18. MOTHER'S N | AME (First, Middle, Mald | en Sumame) | ODEN | V | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Mr. Charles E. Bit: | ler 10 | MAILING 0817 | Old | (Street er Nat: | nd Number or Rural | ike, New M | own, State, Zi arket | p Code) | 217 | 774 |
| | 20er METHOD OF DISPOSITION t & Burlel 2 Cremetton 3 Remove 4 Donation 8 Other (Specify) | 20b. PLACE A | ND DATEO | F DISPOSI | TION / Na | me of | DATE 20c. 1 25, 1995 Fr | OCATION - | City or Toy | vn. Stata | _ |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | | 23. 1 | NAME AN | D ADDRESS OF | asford P.A | - CGCL1 | CR, I | act y i | did |
| | · Richarde. | Draf MOO2 | | 10 |)6 Ea | ast Chu | rch St., F | reder | ick. | Md. | 21701 |
| | 23. PART I. Enter the diseases, or cor shock, or haert failure. Lis IMMEDIATE CAUSE (Finel disease or condition | mplications that caused the deast only one cause on each line. | oth. Do n | ot enter | the mod | de of dying, su | ch as cardiac or res | piratory si | rest, | Inte | proximate erval Between set and Daeth |
| | resulting in death) a. | DUE TO (OR AS A CONSEC | UENCE OF | 7 | | | | | | | y. |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSECU | UENCE OF |): | | | | | | | |
| RTIFIC | CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST | DUE TO (OR AS A CONSEO | UENCE OF |): | | | | | | 1 | |
| S | d | | | | | | | | | - | |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions | contributing to deeth but not re | sulting is | n the un | derlying | ceuse given i | Part I. 24a. WAS / PERF | IN AUTOPSY ORMED? | - | AVAILABLE | OPSY FINDINGS E PRIOR TO ON OF CAUSE |
| I: ME | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF DEAT | TH YE | SPIN | 10 D | UNCERTA | IN [] | | | | 2 NO |
| A | 25. WAS CASE REFERRED TO MEDICAL | | OF DEAT | | - | OTTCERTA | | | | | |
| SI | | IOSPITAL: Inpatient 2 ER/Outpatient 3 | | OTHER | | 5. Haaldence | a [] On (O) | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME | OF | 28c. INJU | JRY AT | 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OC | CURED | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be detarmined | 28s. PLACE OF INJURY — At hombuilding, atc. (Specify) | ne, term, el | treet, facto | | | 281. LOCATION (Stree City or Town, Sta | | r or Rural Ro | oute Numbe | 84, |
| COMPLETED | | AN: To the best of my knowledge, dear | | | | | | | | | |
| 8 | | On the basis of examination and/or in | rvestigation | n, in my op | pinion, de | ath occured at th | e time, data and place, | and due to t | he Cause(a) | and mann | ner as stated. |
| 8 | 296. SIGNATURE AND TITLE OF CERTIFIER | C Ken I. | | | | 29c. LICENSE N | | 29d. DA1 | E SIGNED | (Month, De | |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO | - Ingree | | | | D0511 | 1 | Au | igust | 23, | 1995 |

Hughes, M.D., 700 Montclaire Avenue, Frederick, MD 21701

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Robert S.
31. DATE FILED (Month, Day, Year)

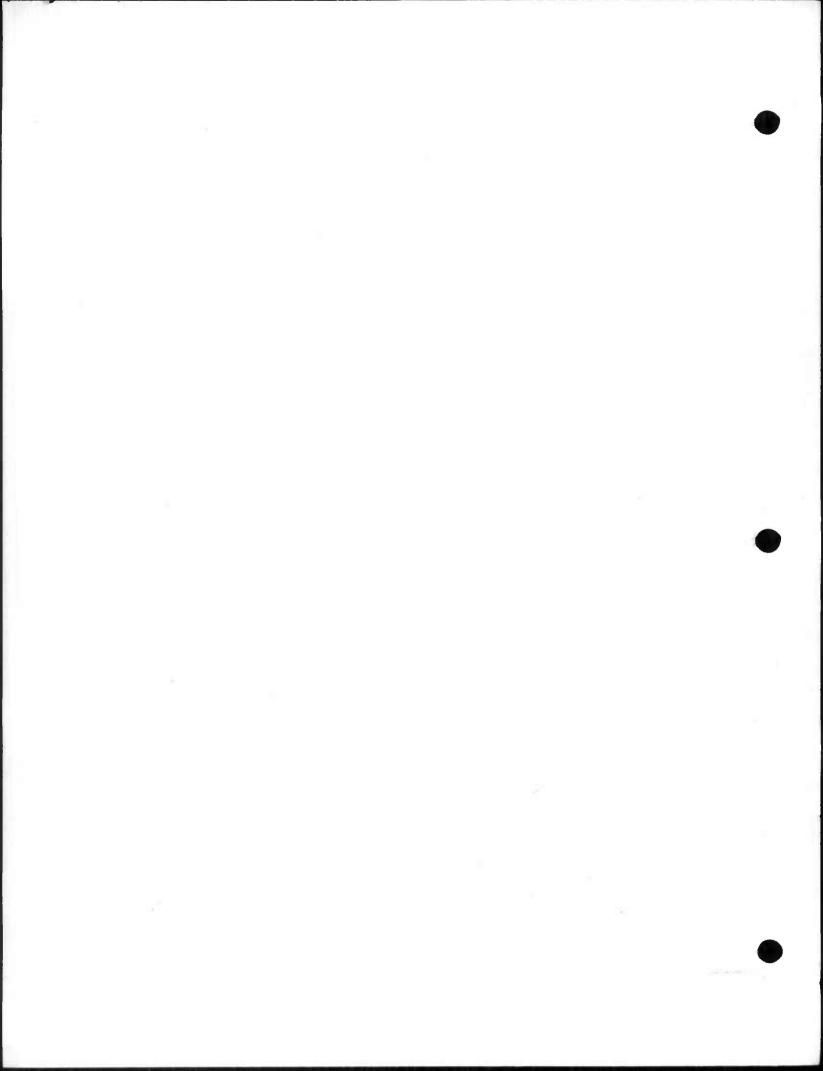
AUG 2 5



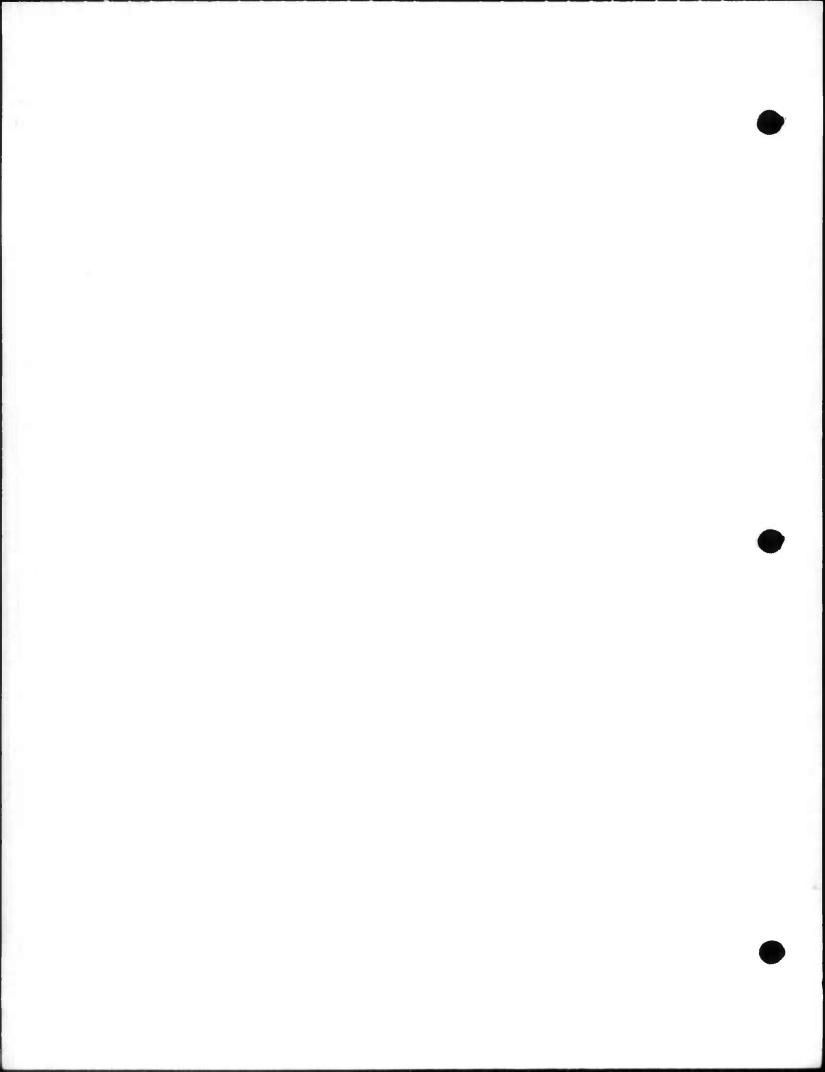
DIVISION OF VITAL RECORDS, P.O. BOX 68760

| O THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should e filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
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| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------|-------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | MAURI | CE STEPHEN | BROWN | 1 | | AUGUST 19 | ,1995 YEAR | 9:25 P M | | | |
| | | S. SEX 8. AGE (In) | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | S. BIR | THPLACE (State or Foreign | | | |
| | 220 11 2713 | ₩ ² □ F 85 | YAS. | PONTHE DAYS | HOURS: MIN. | FEB.11,19 | 10 MIS | SSOURI | | | |
| _ | 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | |
| 6 | WILSON HEALTH CARE CENTER GAITHERSBURG MONT. | | | | | | | | | | |
| E E | RESIDENCE OF DECEDENT | | | | | | | | | | |
| DIRECTOR | MD MO | NT. | | KENSING | CTON | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | 1111 | | | . ZIP CODE | | 10g, CITIZEN OF | WHAT COUNTRY? | | | |
| FUNERAL | 3608 SAUL ROAD | | | | 20895 | | 11 | .S.A. | | | |
| S | | 2. WAS DECEDENT EVER IN U | | 13. WAS DEC | ENDENT OF HISPAN | NIC ORIGIN? (Specify Ye | s or No 14. RA | CE - American Indian. | | | |
| BY F | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 YES | ZNO | If yes, sp | ecity Cuben, Mexica 2 NO Specifi | n, Puerto Rican, etc.) | 1000 | eck, White, etc. | | | |
| ED B | | WW II | | | | | | WHITE | | | |
| E | 15. DECEDENT'S EDUCAT (Specify only highest grade cor | mpleted) | Give kind of wo life. Do NOT use | rk done durina me | ON ast of working | 16b. KIND OF BU | SINESS/INDUSTRY | | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | vil Serv | vide U. | .s. GOVE | RMENT | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | JT | | | | ME (First, Middle, Maiden | | | | | |
| | WILLIAM E. BROWN | | | | THE COLUMN THE PARTY OF THE PAR | LEE CRUSI | | | | | |
| BE (| 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | ODRESS (Street a | | Route Number, City or Tow | | | | | |
| 10 | JANET B. RHUDY | | | | | FAIRFIELI | | 6430 | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remova | 20b. P1 | LACE AND DATE OF | DISPOSITION (N | | OATE 20c. LO | CATION — City or | | | | |
| | 4 Donation 5 Other (Specify) | MO | UNT COME | ORT CRI | MATORY | 8/23 | ALEXANDR | IA. VA | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOS GAWLERS SONS INC. | | | | | | | | | | |
| | Lemond | Semmos | 7 | 5130 V | I AVE NW | WASHINGTO | | | | | |
| | 23. PART I. Enter the disesses, or con | nplicetions that caused ti | he desth. Do no | t enter the mo | ds of dying, suc | h ss cerdisc or resp | iratory arrest, | Approximate | | | |
| | shock, or heart fellure. Lis | t only one ceuse on seci | n ilne. | | | | | Interval Between Onset and Death | | | |
| | disesse or condition resulting in death) | STROKE | | | | | | | | | |
| | | DUE TO (OR AS A CO | ONSEQUENCE OF): | | | | | | | | |
| NO | Sequentially list conditions, b | | | | | | | | | | |
| CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING | OUE TO (OR AS A CO | ONSEQUENCE OF): | | | | | | | | |
| 임 | CAUSE (Disease or Injury c that initiated events | DUE TO (OR AS A CO | ONSEQUENCE OF): | | | | | | | | |
| E | resulting in deeth) LAST | | | | | | | . ! | | | |
| | PART II. Other plantiless and distance | | | | | | | | | | |
| MEDICAL | PART II. Other significent conditions of | | | | g ceuse given in | Part I. 24s. WAS AN PERFOR | | ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| ă | _DIABETES, SEIZURE | S, RECENT SEP | SIS, ANEN | 1IA | | 1 _ YES 2 | ₩ NO | OF DEATH? | | | |
| Σ | DID TOPACCO LICE COLUMN | WITE TO A | | | | | | 1 TYES 2 NO | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIB | | PLACE OF DEATH | | UNCERTAIN | <u>и </u> | | | | | |
| S | EXAMINER? | IOSPITAL: | | OTHER: | | | | | | | |
| H | 27. MANNER OF CEATH | 25e. DATE OF INJURY | 28b. TIME | | e 5 Residence | 5 Other (Specify) 28d. OESCRIBE HOW I | N III BY OCCUBED | | | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJUI | TY WO | RK7 ES 2 NO | Tou. DESCRIBE NOW I | NOONT OCCORED | | | | |
| ЭВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | At home, farm, str | et, factory, offic | | 281. LOCATION (Street a | and Number or Rura | I Route Number, | | | |
| COMPLETED | 4 Homicide determined | building, atc. (Specify) | | | | City or Town, State) | | | | | |
| 7 | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA | N: To the best of my knowled | ge, death occurred | et the time, date | end place, end due | to the cause(e) end may | oner as stated | | | | |
| NO | | On the basis of examination er | | | | | | (e) end manner ee stated. | | | |
| | 296. BIGHATUME AND FITLE OF CENTIFIED | 1 | | | 29c. LICENSE NUN | | | D (Month, Day, Year) | | | |
| BE (| 40000 | fellen | | | D 03518 | | N | ST 21,1995 | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO C | DAPLETED CAUSE OF DEATH | (ITEM 27) (Type, P | rint) | | | 110001 | 2191999 | | | |
| | ELLIOT R. GOLDSTEIN | M.D. 5480 W | VISC. AV | E #LL5 | CHEVY | CHASE, MAR | YLAND 2 | 20815 | | | |
| | 31, DATE FILED (Month, Day, Year) | Duries Paris | | | | | | | | | |
| | AUG 25 1995 | The state of the s | ~~ | | | | | | | | |



| | | 1 - STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------|-----------------------------|---------------------------------------|--------------------------------------|-----------------------|-----------------------|-------------------------------------------------------|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | 2 2 2 2 2 5 | AKA | FREd | | 2. DATE OF DEATH | H | YEAR | 3. TIME OF DEATH | | |
| | | FRED | BARBE | FRU | BAR | BARD | August | 20 | 1995 | 03:33 AM | | |
| | | 4. SOCIAL SECURITY NUMBER | | yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea | 1) | 8. BIRTHP Country) | LACE (State or Foreign | | |
| Pin | | 98. FACILITY NAME (If not institution, give s | 1 X M 2 - F | 92 YRS. | | | SEPT.22, | | Ital | | | |
| I. 2. 3 should | DIRECTOR | Holy Cross Hospi | | | | or Location of DE | | | ontgo | | | |
| permit. Pages 1. | H. | 10e. STATE 10b. COUNTY | | 10c. CI1 | TY, TOWN OR LOCA | TION | | | | 10d. INSIDE CITY | | |
| At. P | | | ntgomery | S | ilver Sp | | | | | 1 YES 2 1 NO | | |
| <u>1</u> | FUNERAL | 10e. STREET AND NUMBER | | | 10 | f. ZIP CODE | | | | IAT COUNTRY? | | |
| 020 physician. burial-transit | N. | 906 Venice Drive | 12. WAS DECEDENT EVER IN | II S ARMED | 12 WAS DEC | 20904 CENDENT OF NISPAN | IC OBIGINS (PIA | | J.S.A | | | |
| 020 physi buria | | 1 Nover Married 2 Merried | FORCES? 1 YES | 2 NO | if yes, sp | ecify Cuban, Mexica 2 1 NO Specify | n, Puerto Rican, atc. | | Black, | - American Indian, White, etc. | | |
| 215-0020 attending physician ise as the burial-trai | BY | 3 Widowed 4 Divorced | | | 1 | a go no opecin | | | Specify. Wh | ite | | |
| or atte | ETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (Give kind of | Work done during me | ON ost of working | 16b. KIND OF | BUSINESS/INDI | JSTRY | | | |
| ND 21 hospital o tached for | F | Elementary/Secondary (0-12) | College (1-4 or 5+) | itte. Do NOT u | | | m . | 1 | | | | |
| AND the hospit detached once. | COMPL | 17. FATNER'S NAME (First, Middle, Last) | | Sell E | mployed | 18 MOTNED'S NA | Tai | | | | | |
| YLA by the be det | U U | John Barbaro | | | | Concet | | cchino | | | | |
| E, MARN y be retained by hage 5 should I | 00 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | 3 ADDRESS (Street a | and Number or Rural F | | | Code) | - | | |
| be ret | 5 | John F. Barbaro | | 906 V | enice Dr | ive Sil | ver Spri | ng,Mary | land | 20904 | | |
| May be or. page | | 20a. METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Remo | 20b.1 | PLACE AND DATE | OF DISPOSITION (N | ame of | DATE 200 | LOCATION | Sites on Town | - Panta | | |
| MO age 6 direct | | 4 Denetion 5 Other (Specify) | Ğa | te of H | eaven Ce | metery 8 | /25/95Si | lver Sr | ring | ,Maryland | | |
| ALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital or attending physic e funeral director, page 5 should be detached for use as the burial. examiner must be notified at once. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE . | | | ND ADDRESS OF FAC S J. Col | | eral Ho | ome, | Inc. | | |
| | Щ | James & | Jany | | 500 Un | iversity | Blvd.,W | . Sil. S | Spr., | MD 20901 | | |
| 5 - 5 5 | | 23. PART i. Enter the diseases, or of shock, or heart failure. | complications that caused | the death. Do o | not enter the mo | ode of dying, auci | as cerdiec or re | apiratory arm | eat, | Approximate Interval Between | | |
| y filled is about the me | | iMMEDIATE CAUSE (Final disease or condition | C 15. | CI. | | | | | | Onset and Death | | |
| d within ompletely I, cremat event, 1 | | resulting in deeth) | DUE TO GRASA O | CONSECUENCE | 500 | | | | | 4 hrs. | | |
| | | | Pre | WWW V | ~~ ~ | | | | | 244.4 | | |
| A 5 - 3 | RTIFICATION | Sequentially list conditions, if any, leeding to immediate | DUE TO (OR AS A | | | | | | | | | |
| BO arte be hysiciar prior | 🛭 | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| other plant of the | | that initieted eventa resulting in death) LAST | OUE TO (OR AS A | CONSEQUENCE O | IF): | | | | | | | |
| J = 2 - 9 | CEH | | 1 | | | | | | | | | |
| I de the | AL (| PART II. Other aignificent condition | contributing to deeth bu | t not reaulting | in the underlyin | g ceuse given in | Part i. 24a. WAS | AN AUTOPSY FORMED? | | YERE AUTOPSY FINDINGS | | |
| 3 = 8 = E | EDIC | | | | | | | S 2 NO | 0 | WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? | | |
| w requires the been signed or, of Health 3 shows and | Σ | | | | | | | | | TYES 2 0 NO | | |
| law law ept begin by base by b | AN | DID TOBACCO USE CONTR | | | | UNCERTAIN | I'Z | | | | | |
| VITAL AN: The law lificate has state Dep | SICIAN | EXAMINER? 1 YES 2 NO | HQSPITAL: | | TN (Check only one) OTHER: | | / | | | | | |
| F VIT, SICIAN: Th certificate the State the State | PHYS | 27. MANNER OF OEATN | 1 Nonetlant 2 ER/Outpet | tient 3 DOA | | e 5 Residence | 6 Other (Specify) 26d, DESCRIBE NO | W IN HIEV OCC | · · · | | | |
| NG PHYSIC fter this ce sath with ti | | 1 Netural 5 Pending | (Month, Day, Year) | | JURY WO | PRK? | zou, DESCRIBE NO | W INJURY OCC | UNED | | | |
| 28s. PLACE OF INJURY — At home, farm, street, factory, office 2st LOCATION (Street and Mumber | | | | | | | | | or Rural Ros | ate Number, | | |
| OR ATTEN OR ATTEN DIRECTOR: hours after tem 28 | ETE | 4 Homicide datermined | building, etc. (Specify | y) | | | City or Town, St | ete) | | | | |
| | PLE | 290. CERTIFIER (Check only | CIAN: To the best of my knowled | dge, death occurr | ed at the time, date | end place, end due | to the cause(s) end | manner as state | d. | | | |
| THE HOSPITAL THE FUNERAL filed within 72 PORTANT: 11 | COMPL | | R: On the basis of examination | | | | | | | and manner as ateted. | | |
| HE HO | BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUM | | 29d. DATE | SIGNED (A | Aonth, Day, Year) | | |
| TO THE HOSPIT TO THE FUNER, be filed within 7 | TO B | anne | 7/1 | | | D3789 | 211 | D A | ragus | r 20 1990 | | |
| Ø | | 30. NAME AND ADDRESS OF PERSON WIN | COMPLETED CAUSE OF DEAT | IN (ITEM 27) (Type | Print) | Ln # 40 | 9 Rock | ville 1 | ND 2 | v 20 1996 2085 2 | | |
| J | | AUG 25 1995 | 32. REGISTRAR'S SONAT | Lally | * | - | | | | | | |

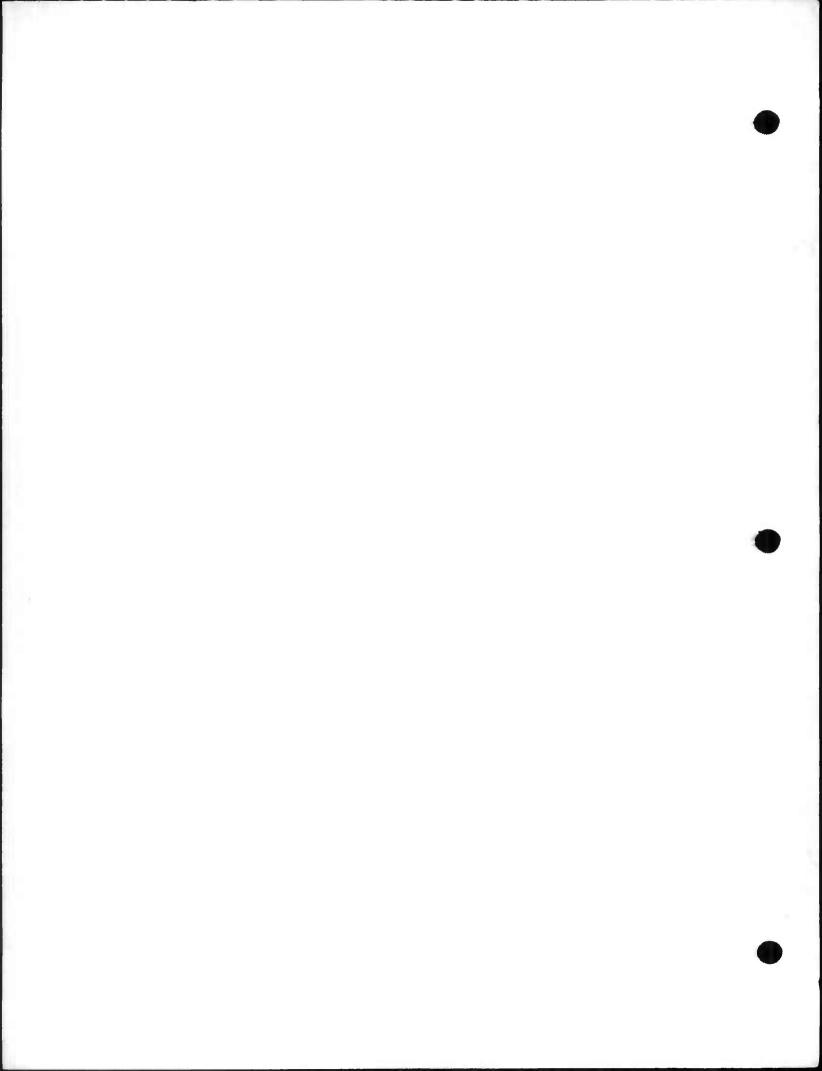


DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 37 hours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| leath. Page 6 may be | funeral director, page | |
| rim hours after c | teh filled in by the | mation, or removal. |
| te be executed with | sician and complet | prior to burial, crer |
| the death certifica | / the attending phy | d Mental Hygiene |
| e law requires that | has been signed by | Dept. of Health an |
| ING PHYSICIAN: Th | ofter this certificate | eath with the State |
| HOSPITAL OR ATTENO | FUNERAL DIRECTOR: / | be filed within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal. |
| THE OF | TO THE | be filed |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEOENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF OEATH |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------|----------------------------------|-------------------|-----------------------------------------|---------|---------------------------|-------------------------------------------------|-----------------------------------|------------|------------------|------------------------------------------------------------------------------------|
| | | Russell | Parke | r Bowie | | | | | | | August 21 | | YEAR | 10:36 P M |
| - 1 | | 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 6. AGE (In yrs. | lest birthday) | IF UNDER | | IF UNDER 2 | | 7. DATE OF BIRTH | , | S. BIRTH | PLACE (State or Foreign |
| ., | | 577-22-7189 | 9 | 1 M 2 D F | 71 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) Feb. 20, 19 | 24 | Washington, D.C. | |
| should | | 9a. FACILITY NAME (If not in | estitution, give s | treet and number) | | | 96. СІТУ, | TOWN | OR LOCATIO | N OF DE | | 7 | NTY OF D | |
| 2, 3 | OR | Holy Cross | Hospi | tal | | | Si1 | ver | Spri | ng | | N | lonte | omery |
| | DIRECTOR | RESIDENCE OF DEC | 10b. COUNT | · | | 40a CITY | IC. CITY, TOWN OR LOCATION | | | | | | 1 | |
| Page | E | | | tgomery | | | | | | | | | - 1 | 10d. INSIDE CITY LIMITS? |
| permit. Pages | | Maryland 100. STREET AND NUMBER | K | ensi | | On . ZIP CODE | | | L | | 1 YES 2 NO | | | |
| sit pe | HA. | 10709 Bruns | | A == = == == | | | | | | | | | HAT COUNTRY? | |
| burial-transit | FUNERAL | 11. MARITAL STATUS | SWICK | 12. WAS DECEDEN | IT EVER IN U.S. | ARMED | 13. 1 | _ | 20895 | HISPAN | IC ORIGIN? (Specify Yes | or No | U.S. | A . — American Indian. |
| buri | | 1 Never Married 2 | | | YES 2 | NO | 1 | yes, sp | | Maxicar | , Puerto Rican, atc.) | 0, 110 | Black | , White, atc. |
| as the | ВУ | 3 Widowed 4 Divo | orced | WW | | | | | 2 (3-110 | opacity. | | | Whi | • |
| use a | ED | | EDENT'S EDU y highest grade | | 16a. | DECEDENT'S L | ork done o | CUPATIO | ON ost of working | | 16b. KIND OF BU | BINESS/INC | DUSTRY | |
| lo. | COMPLET | Elementary/Secondary (I |)-12) | College (1-4 or 5 | | life. Do NOT use | retired.) | | | | | | | |
| detached once. | ₹ I | 12 | | | Ma | rketin | g Ma | nag | 7 | | Telep | | | |
| be det | - | 17. FATHER'S NAME (First, M | | | | | | | | | #E (First, Middle, Maiden | Surname) | | |
| 2 pg | BE | Randolph Bo | | | | | | | | - | arker | | | |
| 5 should notified | 2 | The state of the state of | | | | | | | | | loute Number, City or Tow | | , | |
| be p | | Patti L. Stenger 10708 Brunswick Avenue Kensington, Maryland 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of 200. LOCATION — City or Town, \$16 | | | | | | | | | | | | |
| the funeral director, page oval. | | 1 N Burial 2 Crematic | on 3 🗆 Ram | oval from State | cemetery. | crematory or oth | wn Cemetery 8/25/95 Rockville, Maryland | | | | | | | |
| die | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, | | | | | | | | | | | ryland | |
| tuneral di examiner | 126 tol | | | | | | | anc | is J. | Co1 | lins Fune: | | | |
| of in by the funeral director, page 5 should be detached for use as the burial-train or removal. medical examiner must be notified at once. | | 23. PART I. Enter the d | cre c | | nsu | | 50 | 0 U | niver | sity | Blvd.,W. | Sil. | Spr. | ,MD 20901 |
| DIRECTOR: After this certificate has been signed by the attending physician and completely fillinours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, item 28 is marked, or item 23 shows any injury, or other traumatic event, the | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | | years | | |
| signed by Health and ws any I | MEDICAL CE | PART II. Other significa | ent condition | s contributing to | deeth but no | ot resulting in | the un | derlyin | g couse gl | ven in i | Part I. 24a. WAS AN PERFOR | MED? | 246. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| has been Dept. of 23 sho | AN: | DID TOBACCO U | SE CONT | RIBUTE TO CA | USE OF D | EATH YES | | 10 E | UNCE | RTAIN | 12 | | | |
| State Dept. | S | 25. WAS CASE REFERRED T EXAMINER? | O MEDICAL | HOSPITAL: | 26. PI | ACE OF DEATH | | | | | | | | |
| the St | YSICI | t TYES 2 NO | | 1 Inpatient 2 | ER/Outpatient | | OTHER | | e 5 🗆 Resi | idence (| B ☐ Other (Specify) | | | |
| After this certificate death with the State marked, or item | ву Рн | | Pending Investigation | 28a. DATE OF (Month, D | INJURY Pay, Year) | 28b. TIME INJU | | | URY AT ORK? YES 2 [| но | 26d. DESCRIBE HOW II | NJURY OC | CURED | |
| DIRECTOR, After hours after death item 28 is man | ETED | | Could not be determined | 28s. PLACE O building, | OF INJURY — At atc. (Specify) | home, farm, st | m, street, factory, office 28f | | | 28f. LOCATION (Street a City or Town, State) | nd Number | or Rural R | oute Number, | |
| 30 = | MPL | | | | | | | | | | to the cause(a) and mar | | | and manner as stated. |
| TO THE FUNERAL be filed within 72 IMPORTANT: IF | O BE CO | 29b. SIGNATURE AND THE | | | hall | | | | 29c. LICEN | | | | | (Month, Day, Year) |
| , , | ۲ | 30. NAME AND ADDRESS OF | PI | COMPLETED CAUSE | SE OF DEATH (| TEM 27) (Type, 1 | Print) | SEO, | RBIA | Ave | - SILVER | SPRIN | G | 40 20902 |
| _/ | | 31. DATE FILED (Month, Day, | 995 | July David | LON CONTUR | II, | | | | | | | | |



| BALTIMORE, MARYLAND 21215-0020 | certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicid |
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| .O. BOX 68760 | pecute |
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| - | O |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

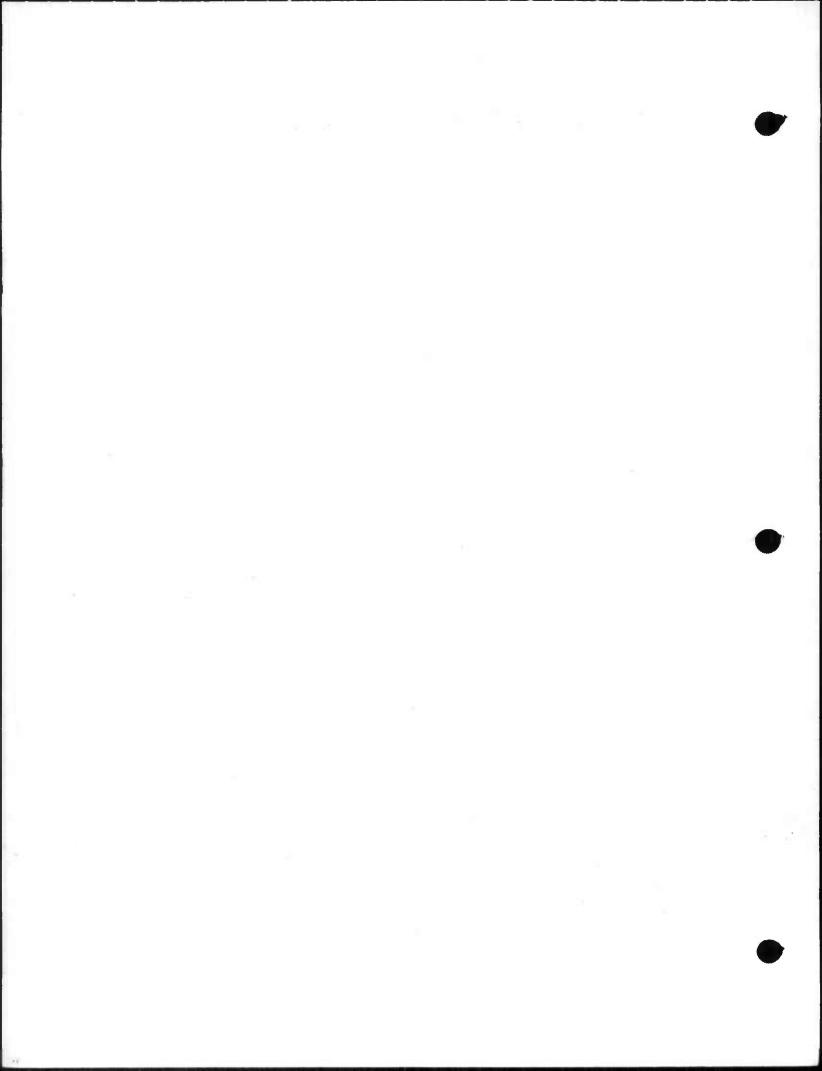
TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.

| | | | | | | | 95 | 2/015 | | | | | |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------|-----------------------|-------------------------|------------------------------------------------|-------------------------------|--------------------------------------------------|--|--|--|--|--|
| | FOR STATE REGISTRAR | STATE OF MAR | | RTMENT OF | | MENTAL HYGIEN | | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | |
| | Lillian Cecilia | Bowles | | | | | | EAR 1 50 A M | | | | | |
| | | | GE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | August 23 | | 1:50 A M BIRTHPLACE (State or Foreign | | | | | |
| | 215-36-5108 | □ M 2 □ F | | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | Country) | | | | | |
| | 9a. FACILITY NAME (If not institution, give stree | - 1 | 91 YRS. | - | | June 6, 19 | | shington, D.C. | | | | | |
| 00 | | , | | 96. CITY, TOWN | OR LOCATION OF D | EATH | 9c. COUNTY | OF DEATH | | | | | |
| 0 | Kensington Gardens | Nursing H | lome | Kei | nsington | | Mor | ntgomery | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | TY, TOWN OR LOCA | TION | | | 10d. INSIDE CITY | | | | | |
| <u>E</u> | | LIMITS? | | | | | | | | | | | |
| | Maryland Moni | 1 TES 2 NO | | | | | | | | | | | |
| FUNERAL | 108. STREET AND NUMBER | | | 1 | of. ZIP CODE | | 10g. CITIZEI | N OF WHAT COUNTRY? | | | | | |
| 9 | 13706 Frankfort Co | U. | S.A. | | | | | | | | | | |
| 5 | | 2. WAS DECEDENT EVI FORCES? 1 Y | | 13. WAS OF | CENDENT OF HISPA | NIC ORIGIN? (Specify Vent, Puerto Rican, atc.) | a or No- 14 | . RACE — American Indian, Black, White, atc. | | | | | |
| ВУ | 1 Never Merried 2 Married 3 X Widowed 4 Divorced | IF YES, GIVE WAR O | | | S 2 NO Specific | | | Specify: | | | | | |
| | o Da whoma | | | | | | | White | | | | | |
| | 15. OECEDENT'S EDUCAT (Specify only highest grade co. | TION mpleted) | (Give kind of | WORK done during in | ION ost of working | 16b. KIND OF BU | ISINESS/INDUS | TRY | | | | | |
| | | College (1-4 or 5+) | life. Do NOT u | use retired.) | | | | | | | | | |
| 를 | 12 | | Homema | ker | | Own | 1 Home | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maider | Sumame) | | | | | | |
| BE | Thomas James Galla | agher | | | Cecilia | Lillian N | <i>i</i> cInnis | | | | | | |
| 6 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | D ADDRESS (Street | and Number or Rural | Route Number, City or To | vn, State, Zip Co | nde) | | | | | |
| F | William W. Bowles | | 13706 | Frankfo | ort Court | Rockvil | e.Marv | land 20853 | | | | | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE | OF DISPOSITION (A | | | | y or Town, Stata | | | | | |
| | 1 XBuriel 2 Cremation 3 Remove 4 Donation 8 Other (Specify) | il from State | Cate of H | other place) | matary 8 | /25/05C+1 | ion Con | ina Mayuland | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISER | Galle OI II | 22. NAME / | IND ADDRESS OF FA | ACILITY | ver spr | ing,Maryland | | | | | |
| | No hute | (0000 | | Franc | is J. Col | lins Funer | al Hom | ne, Inc. | | | | | |
| 500 University Blvd., W. Sil. Spr., MI | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or con abock, or heart failure. Lie | nplications that cau | the deeth. Do | not enter the m | ode of dying, suc | ch as cardiac or reap | olratory arrea | t, Approximate Interval Between | | | | | |
| | IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | | |
| | disease or condition resulting in death) | INI | NOMUS | ūΑ | | | | 2 days | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| Z | Sequentially list conditions, | | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate | | | | | | | | | | | | |
| 2 | CAUSE (Disease or injury | | | | | | | | | | | | |
| 1 1 1 | that initiated events | DUE TO (OR / | AS A CONSEQUENCE O | OF): | | | | | | | | | |
| H | reaulting in death) LAST | | | | | | | | | | | | |
| 1 - 11 | PART II. Other aignificent conditions of | contributing to deal | h but not resulting | in the underlyis | on course of the land | Part I. 24e. WAS AI | | | | | | | |
| MEDICAL | Cold II Wal | c 0 | A /- | | ig couse givan in | | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | | |
| Ö | C. 286000 1000 | 1 YES | 2 NO | OF DEATH? | | | | | | | | | |
| Σ | | | | | | | | 1 TYES 2 NO | | | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIB | BUTE TO CAUSE | | | | NIX | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | 28. PLACE OF DEA | |) | | | | | | | | |
| S | | ☐ Inpatient 2 ☐ ER/ | Outpatient 3 DOA | OTHER: | ne 5 🗆 Rasidence | 8 Other (Specify) | | | | | | | |
| [] | 27. MANNER OF DEATH | 28a. DATE OF INJU (Month, Day, Ye. | | | JURY AT | 28d. DESCRIBE HOW | IED | | | | | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Mornin, Day, 16 | IN. | | ORK? YES 2 NO | | | | | | | | |
| 8 | 3 Suicide 6 Could not be | 28a. PLACE OF INJ | URY — At home, ferm, | street, factory, offi | ca | 28f. LOCATION (Street | and Number or | Rural Route Number, | | | | | |
| ш | 4 Homicide determined | building, atc. (| Specify) | | | City or Town, State |) | | | | | | |
| COMPLET | 29a. CERTIFIER | N. T. M. b. st. of | | | | | | | | | | | |
| ₽ B | | | | | | to the cause(a) and me | | | | | | | |
| | On the basis of examin | ation and/or investigation | on, in my opinion, | death occured at the | time, data and piece, a | nd due to the c | ause(s) and manner as atated. | | | | | | |
| | | | | | 29c. LICENSE NUI | MBER | 29d. DATE S | IGNED (Month, Day, Year) | | | | | |
| w | 29b. SIGNATURE AND TITLE OF CERTIFIER | | MD. | | ZPC. CICENSE NO | | | IGNED (Month, Day, 1987) | | | | | |
| | 73 | Three | - S. LIA | AN MO | D24 | 10// | 18- | 23-95 | | | | | |
| BE | 73 | OMPLETED CAUSE OF | DEATH (ITEM 27) (Type | AN MO | D24 | 10// | 18- | | | | | | |
| BE | 30. NAME AND ADDRESS OF PERSON WHO CONTROL AND ADDRESS OF PERSON WHO CONTR | COMPLETED CAUSE OF | SILA DEATH (ITEM 27) (Type | , Print) | D24 | 20910 | 18- | | | | | | |

32 AEGISTRAN'S MATURE. Daniels hardal

31. DATE FILED (Month, Day, Year)
AUG 25 1995



3. TIME OF DEATH

Approximate interval Between Onset and Death rears

| 68760 | - |
|------------|---|
| BOX 687 | |
| P.O. | |
| L RECORDS. | |
| LREC | |
| OF VITAL F | |
| NOF | |
| OISIN | |
| | |

Dohn

31. DATE FILED (Month, Day, Year) AUG 24 1995

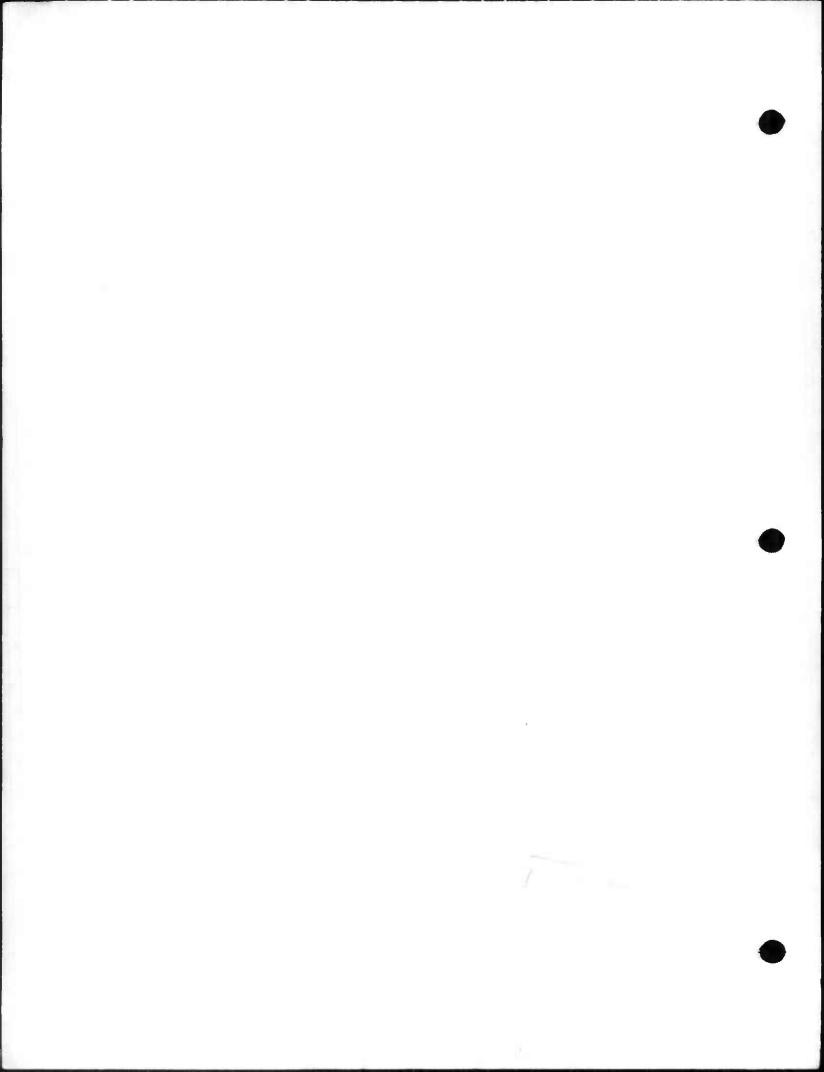
| | | 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------|------------|--------------|--------------------------------|---------------------|------------|-----------|------------|-------------------------------------------------------|----------------------------------|-----------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, | | G | | - | 3 | 49, | | | | MON | E OF DEATH | AY | YEAR | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 'In yrs. les | t birthday) | F UNDE | R 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE | OF BIRTH | 2 | 8. BIRTH | IPLACE (State or Foreign |
| 2 | | 217-36-5722 | | 1 M 2 X F | 8 | 35 | YRS. | MONTHS | DAYS | HOURS | MIN, | Mar | th, Day, Year) ch 29, | 1910 | Kan | n) ISAS |
| 2, 3 should | (c) | | 9e. FACILITY NAME (If not institution, give sti | | | | | | | OR LOCAT | ON OF D | EATH 9c. COUNTY OF DEATH | | | | |
| | 015 | 11003 Cone L | | | Wheaton | | | | | | | ontg | omery | | | |
| Sages | DIRECTOR | · (| 10b. COUNT | | | | | Y, TOWN | | TION | | | | | | 10d, INSIDE CITY LIMITS? |
| permit. Pages 1, | | Maryland | Mon | tgomery | | | W | heat | _ | . ZIP COO | E | | | 40- 017 | TEN OF I | 1 YES 2 NO |
| 13E | ERA | 11003 Cone L | ane | | | 20902 | | | | | iog. Gri | | | USA | THAT COUNTRY? | |
| YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-transit at once. | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 N 3 Wildowed 4 Divorce | | 12. WAS DECEDER FORCES? | I YES | 2 K N | NO If yes, specify Cuben, Mexi | | | | | | | | No— 14. RACE — American Indian, Black, While, atc. Specify: | |
| 215 attend | G | 15. DECE (Specify only | DENT'S EDU | | | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | DN | | 16 | b. KIND OF BUS | SINESS/IN | DUSTRY | White |
| D 21; spital or ed for us | <u> </u> | Elementary/Secondary (0-1 | | Cotlege (1-4 or 5+) Iffe. Do NOT use retired.) | | | | ng | EDUCATION | | | | | | | |
| AND the hospit detached once. | COMPL | 17. FATHER'S NAME (First, Mid | idle, Last) | | | ILP | CHER | | - | 18. MOT | HER'S NA | | Middle, Meiden | | | - |
| A A A | 111 | Jake Ayers | | | | | | | Ros | a Ka | u1 | | | | | |
| MAR retained 5 should notified | 5 | 190. INFORMANT'S NAME (Typ. | SC 1/411 | | | | | | | | | | nber, City or Tow | | | |
| ay be | | Stephen A. B | H | | 20b | | | unte | | | Trai | . I DA | | Mar CATION - | | d 20854 |
| MOF Pe 6 m rector, | | 1 🔯 Buriel 2 🗆 Cremation 4 🗆 Donation 5 🗆 Other (S | | oval from State | Pa | rkla | matory or o | ther place) emet | ery | | 8 | | 95 Rocl | | | |
| BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic by the funerial director, page 5 should be detached for use as the burial noval. | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc 500 University Blvd.W. Sil.Spr.MD 20 | | | | | | | | | | Inc. | | | | |
| C 3 at | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | | | | | |
| DO DO E | | IMMEDIATE CAUSE (Fine | ert failure. | List only one car | use on e | ich line | | | | | | | | | | Interval Between Onset and Deat |
| od within 24 completely filly i. cremation, event, the | | disease or condition resulting in death) | > | B. Ou deriosclerate Heart Disease | | | | | | | | 2 years | | | | |
| B 2 3 3 | - | | _ | DUE TO | OR AS A | CONSEC | UENCE O | F): | | | | | | | | |
| De e cian or to or to | ERTIFICATION | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN | ete G | DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| O. B. ertificate ing physiqiene puther i | IFIC | CAUSE (Disease or Injury that initiated events | | | | | | | | | | | + | | | |
| . 0 5E F | CERI | resulting in death) LAST | | d | | | | | | | | | | | | |
| 5 4 4 5 E | DICAL (| PART II. Other algnifican | t condition | e contributing to | deeth be | ut not re | eaulting | in the un | deriying | g cause (| given in | Part I. | 24a. WAS AN PERFOR 1 YES 2 | MED? | 24b. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| w requires that been signed by it. of Health and shows amy | MEDIC | | 11 | | | | | | | | | | 1 YES 2 NO | | | |
| law law Dept. | AN | DID TOBACCO US 25, WAS CASE REFERRED TO | | RIBUTE TO CA | | | | S | | UNC | ERTAI | 1 🗆 | | | | |
| 一年 电电话 | SICI | EXAMINER? | MEDICAL | HOSPITAL: | | | | OTHER | 1 : | | 1 | 4 On | | | | |
| the the | PHYSICIAN: | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | ativiti 3 | 28b. TIM | E OF | 26c. INJ | URY AT | sidence | e 6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED | | | | |
| DING PHYS After this death with s marked, | 8Y F | Natural 5 Pe | ending vestigation | (Month, D | лиу, тошг) | | INJ | M | | RK? |] NO | | | | | |
| TTENDI TTOR: A after of | 8 | | ould not be stermined | | | | | | | | or Rural R | oute Number, | | | | |
| E Pond | PLET | 29e. CERTIFIER (Check only | YING PHYSI | CIAN: To the best of | my knowl | edge, des | th occum | d at the t | lme, date | end place | , end due | to the ca | use(e) end man | ner ee stat | ed. | |
| HOSPITAL FUNERAL within 72 | F 1 | | | | | | | | | | | | | | | end menner es stated. |
| TO THE HOSPIT TO THE FUNERA De filed within 7 | BE C | 29b. SIGNATURE AND TITLE O | F CERTIFIE | 7 | | | | | | | ENSE NUM | | | 29d. DAT | E SIGNEO | (Month, Day, Year) |
| DE DE SE | 6 | 30. NAME AND ADDRESS OF I | DEBEON WIT | COMPLETED COM | PE OF PE | 711 | > | Out of | | 200 | 38 | 14 | | • | Aug | 45T 21 9 |
| | 1.1 | ON HAME MIND ADDRESS OF I | FUSON MH | O COMPLETED CAU | DE UF DE | AIM (ITEN | 27) (Type, | rint) | | | | | | | | 1 |

32. REGISTRAR'S SIGNATURE
Aboute Randall

8218 WISONSIN

Bell

AUR

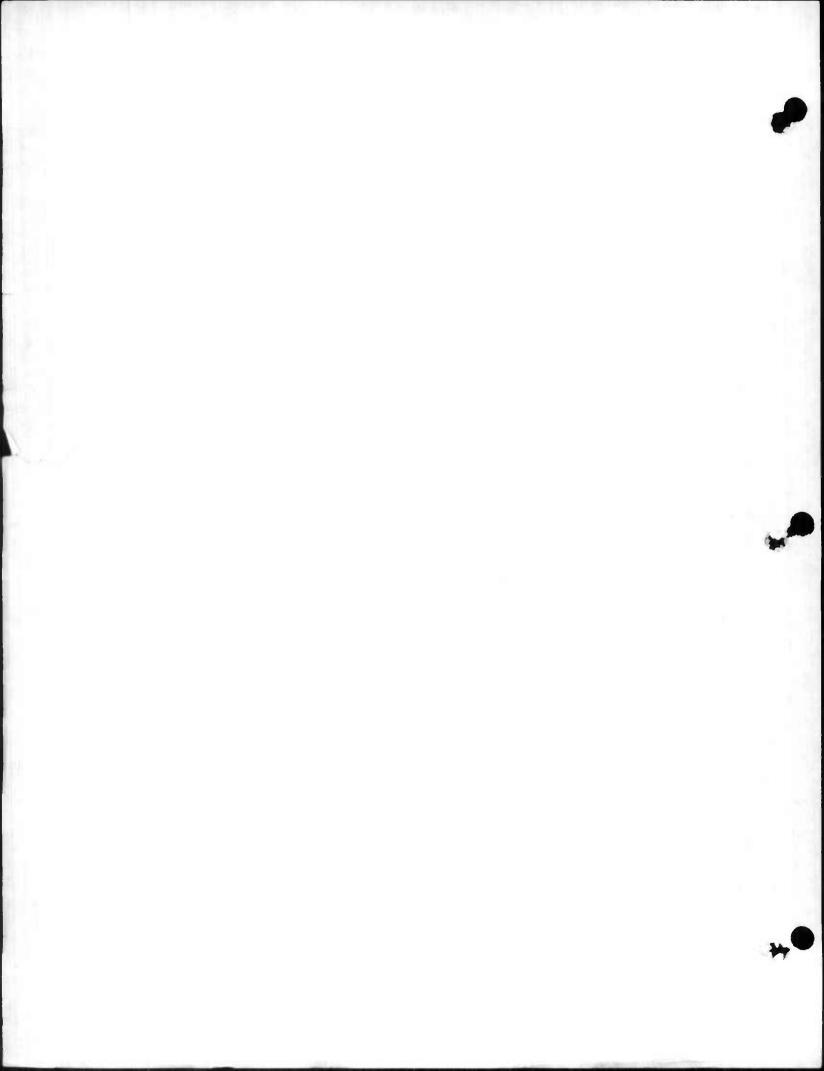


VOID
CERTIFICATE # 95-27017

SEE

CERTIFICATE #

95-33915



| O, BALLIMORE, MARILAND ZIZOS-3140 | withi, muns after death. Page 6 may be retained by the hospital or attending physician. | O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should entitle many with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | vent, the medical examiner must be notified at once. |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOA 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: | TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely med in by the full be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAND / | | TMENT ICATE | | | | MENTA | L HYGIENI REG. NO. | Ē | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------|------------|----------------|------------------------------------|-----------------|-----------|-------------|-----------------------------------|-----------------------------|------------------------------|-----------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 3 B | OHLIG | (a) | JR | 2 . | | | 2. DATE | | y yı | EAR | 2 CAAAM | |
| | 4. SOCIAL SECURITY NUMBER | IL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthe | | | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | OF BIRTH | 8. | BIRTHPLACE (State or Foreign | | |
| | 337-09-3409 | 1, M 2 D F | 87 | YRS. | MONTHS | MONTHS DAYS HOURS MIN. | | MIN. | | n, Dey, Year) | 908 Illinois | | nois | |
| | 9a, FACILITY NAME (If not institution, give s | 42 | 07 | | 9b. CITY | , TOWN | OR LOCATI | ON OF DE | | 119 12 | 9c. COUNTY | | | |
| Œ | Manan Cana | C - 1 | | C | | | | Manh | | | | | | |
| 16 | Manor Care | | | | Silver Spring | | | | | | Mont | gomer | У | |
| DIRECTOR | 10s. STATE 10b. COUNT | Υ | | 10c. CIT | Y, TOWN C | R LOCA | TION | | | | 100 | I. INSIDE CITY | | |
| 1 1 | Maryland N | ontgomer (| v | | Silv | er : | Sprin | 12 | | | 1 [| YES 2 NO | | |
| 1 | 10e. STREET AND NUMBER | | | • | 101. ZIP CODE | | | | | | OF WHAT | COUNTRY? | | |
| E | 2501 Musgrove Roa | a d | | | | | 209 | 204 | | | SA | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDER | IT EVER IN U.S. AF | | | | ENDENT (| OF HISPAN | | N? (Specify Yes | | | American Indian, hite, etc. | |
| | 1 Never Merried 2 Merried | | MAR OR DATES | NO | | | | | | Ricen, etc.) | | Black, WI Specify: | ille, etc. | |
| B | Mildered 4 Diseased | | | | | | | | | | | | White | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | | | Work done | | | ing. | 16b | . KIND OF BUS | SINESS/INDUS | TRY | | |
| 1 | Elementary/Secondary (0-12) | College (1-4 or 5 | - lite | Do NOT L | se retired.) | uumg m | JOSE OF WORK | · · W | | | | | | |
| 릴 | 12 | | Ca | arpei | nter | | | | | Carpent | ry | | | |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, | Middle, Maiden | Surname) | | | |
| BE (| Henry George Bol | nlig, Sr. | | | | | L | illia | an | Schai | rf | | | |
| | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | | |
| 욘 | Del Hannigan 13112 Greenmount Avenue Beltsville, Maryland 20705 | | | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State other place) | | | | | | | | | | | | | |
| | 4 Donestion 5 Other (Specify) St. Mary's Cemetery 8/21/95 Evergreen, Illinois | | | | | | | | | | | | | |
| | 21. SIONATURE OF SUMERAL SERVICE LI | CENSEE | | | 22. | NAME A | ND ADDRE | SS OF FA | CILITY | | Silling Charles and Machine | | | |
| | K-hut | Francis J. Collins Funeral Home, Inc. | | | | | | | | | | | | |
| \vdash | 500 chiversity bivd.; w. bii.bbi.; hb 20001 | | | | | | | | | | Approximate | | | |
| | ahock, Dr haart failure. List Dniy one cause on goan line. | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | | |
| | disease pr condition | | | | | | | | | | | | | |
| | SOFT TISSUE INFECTIONS | | | | | | | | | | | | | |
| 8 | Sequentially list conditions, DUE TO (OR AS A CONSCIUENCE OF) | | | | | | | | | | | | | |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING INANITION AND IMOBILITY | | | | | | | | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST SEJERE DEMENTIA | | | | | | | | | | | | | |
| U U | | | | | | | | | | | | | | |
| ¥ | PART ii. Other aignificant conditio | | | - | | | | | | 24a, WAS AN PERFOR | | AM | RE AUTOPSY FINDINGS AILABLE PRIOR TO | |
| | | | | | | | | | | | MPLETION OF CAUSE DEATH? | | | |
| MEDICA | | | | | | | | | | | | 1 [| YES 2 NO | |
| Ë | | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | QTHE | | LACE OF | DEATH (C) | heck only o | nne) | | | | |
| \S | 1 TYES 2 NO | | ☐ ER/Outpatient | 3 🗆 DOA | | | me 8 🗆 F | Residence | 8 🗆 Oth | er (Specify) | | | | |
| F | 27. MANNER OF DEATH 1 Netural 5 Pending | 28s. DATE O (Month, | F INJURY Day, Year) | 28b. Ti | MÉ OF LJURY | | JURY AT ORK? | | 28d. DE | SCRIBE HOW | INJURY OCCUI | RED | | |
| B | 2 Accident investigation | | | | М | | YES 2 | □ NO | | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE building | OF INJURY — At h I, etc. (Specify) | ome, ferm | street, fac | tory, offi | Ce | | | CATION (Street or Town, State, | | Rural Rout | a Number, | |
| | | | | | | | | | | | | | | |
| COMPLET | 29e. CERTIFIER (Check only one) CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as atted. | | | | | | | | | | | | | |
| Ö | 2 MEDICAL EXAMIN | | examination end/or | investigat | ion, in my | opinion, | | | | e and place, a | | 300,000 | | |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIE | ERI R | | 111~ | | | | CENSE NU | | 0 | | _ | onth, Dey, Year) | |
| 0 | Marie | Mr 19M | m | MD | | | | 251 | 56 | 5 | 1400 | 1001 | 11), 1995 | |
| | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CA | USE OF DEATH (IT) | EM 27) /5/ | o Printl | | | | | | 40.4.1 | | 2 | |

CHAPLES M

31. DATE FILED (Morth, Day, Year)

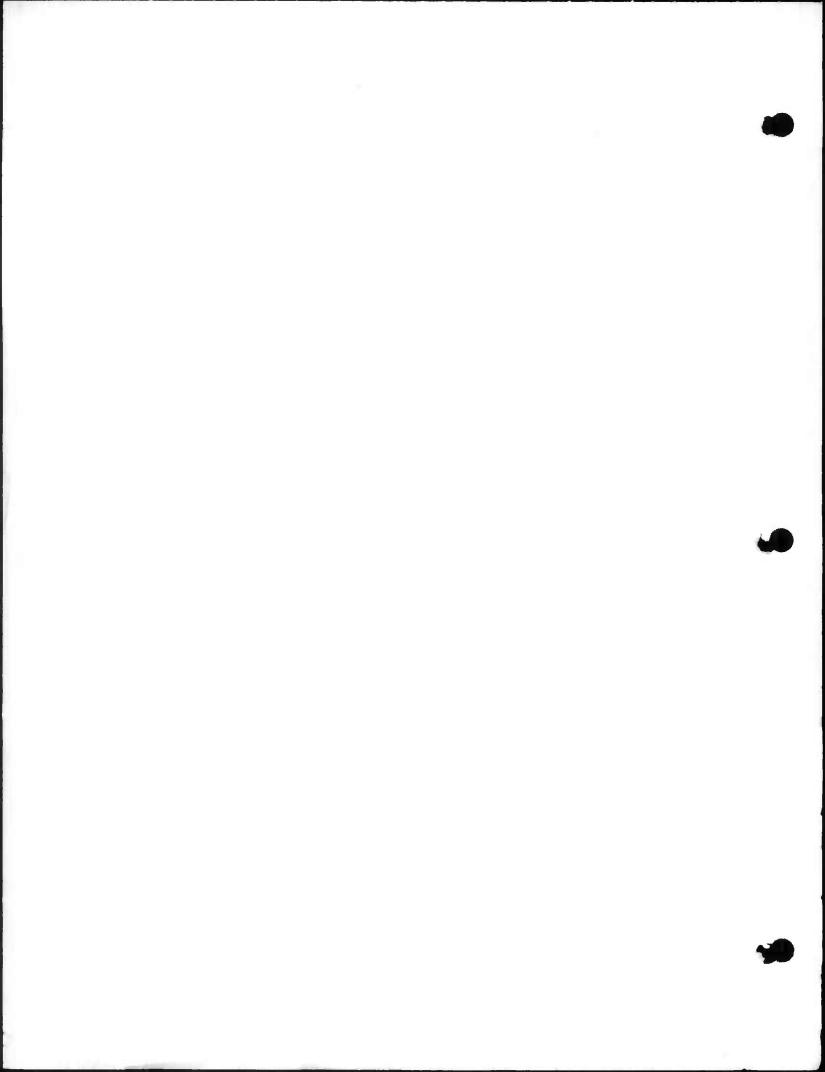
AUG 21 1995 32. REGISTRAN'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CHAPLES M BENNER MD 11251

MD 20901

LOCKWOOD DRIVE,



funeral director, page 5 should be detached for

filled in by the filon, or removal.

cremation, or

ysician and completely prior to burial, crematic

the attending physician Mental Hygiene prior to

been signed by the pt. of Health and M

has b Dept.

certificate I

with 1

After 1

DIRECTOR: hours after

Pages 1, 2, 3 should

permit.

REGISTRAR

| | d |
|-----------------------------|---------------------------------------------|
| | hours |
| | 24 |
| 90 | within |
| 687 | cate he executed within 24 hours a |
| × | 2 |
| , P.O. BOX 68760 | The law requires that the death certificate |
| d. | hath |
| מ | di. |
| H | that |
| RECO | requires |
| _ | 34 |
| 4 | The |
| DIVISION OF VII AL RECORDS, | PITAL DR ATTENDING PHYSICIAN Th |
| SICE | STENDING |
| 2 | DR / |
| | PITA |

1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Stella Best 1995 6:40 August 10 P 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 88 316-05-5245 D 1 M 2 X F YRS. June 16, 1907 Greece Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Potomac 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 26 Buckspark Court 20854 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexicen, Puerto Ric 1 TES 2 NO Specify: BY 3 ₺ Widowed 4 □ Divorced White 16e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or 5+) COMPL 0 Homemaker Own Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Valltos notified at Polyanthe Unobtainable 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 James L. Best 26 Buckspark Court, Potomac, Maryland 20854 must be 20e, METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Parklawn Memorial Park 4 Donation 6 Other (Specify) 8/14 Rockville, Maryland injury, or other traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITYHines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Myocardial Infarction Acute resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular Disease Indef. CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any Hypertensive Cardiovascular Disease 1 TYES 2 DE NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 1 YES 2 NO B Investigation 2 Accident 26e. PLACE OF INJURY — At home, farm, street, tectory, office building. etc. (Specify) Sulcide 28 Is 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide ltem. 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II (Check only one) 2 X MEDICAL EXAMINER: On the beele of ext on end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) and menner as stated. 206. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE NUST 11 0 CAUSE OF DEATH (ITEM 27) (Type, Print) Frances G. Mayle, M.D. 10215 Fernwood Road, Bethesda, Maryland 20817 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE AUG 21 1995 Julia Davidson Revolate DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

BALTIMORE, MARYLAND 21215-0020

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LAURA LYNNE BACKUS AUGUST 18 A SOCIAL SECURITY MIMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MARCH 700 515-84-2519 1 - M 2 X F 24 YRS. HOURS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR NATIONAL INSTITUTES OF HEALTH BETHESDA RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION KANSAS WYANDOTTE KANSAS CITY FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 1877 PRAUN LANE 66102 n by the funeral director, page 5 should be detached for use as the burial-transit removal. executed withher 4 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexicen, Puerto Rican, atc.)

1 YES \$75 NO Specify: 1 Never Married 2 Married 3 Widowed 4 Divorced BY COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT MEDICINE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First. Middle, Maiden Surname) FREDERICK A. BACKUS ANITA LYNNE MOORE BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FREDERICK A. BACKUS 1877 PRAUN LN. KANSAS CITY, KS. 66102 2 20e METHOD OF DISPOSITION
1 A Surial 2 Cremation 3 X III 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must MEMORIAL GARDENS 18 KANSAS CITY, KS. 4 Donation 5 Other (Specify) CHAPEL HTLL examiner 21. SIGNATURE OF FUNERAL SERVICE DICENSES JOSEPH GAWLER STYSONS, INC 5130 WI. AVE. N.W. WASHINGTON, D.C. 20016 medical 23. PART i. Enter the diseases of cations that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by shock, or heart failure. List only one cause on each ilne. Hygiene prior to burial, cremation, or IMMEDIATE CAUSE (Final MONARY the HEMORHAGE disease or condition_ reauiting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF BURKITT LYM PHOMA CERTIFICATION and Sequentially list conditions, if any, leading to immediate DUE TO attending physician the death certificate be 4 cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 signed by the atter Health and Mental injury. PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY that any wampour topremin 1 - YES 2 - MG requires shows newton remin has been ď DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) Item TO THE HOSPITAL DR ATTENDING PHYSICIAN: The TO THE FUNERAL DIRECTOR: After this certificate to field within 72 hours after death with the State IMPORTANT: If Item 28 is marked, or Item HOSPITAL: OTHER: 1 | YES 2 | 10 Impatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Realdence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER'OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural BY 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the baels of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 296. SIGNATURE AND TITKE OF CERTIFIER BE 29c. LICENSE NUMBER 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) (9000 ROCKVILLE PIKE BETHESDA, MARYLAND, , 32. REGISTRAR'S SIGNATURE

his Develor Rendall

23 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2. DATE OF DEATH MONTH

95 27020

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

XX YES 2 NO

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 TES 2 NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year) 195

Interval Between

Onset and Death

WASHINGTON

9c. COUNTY OF DEATH

U.S.A.

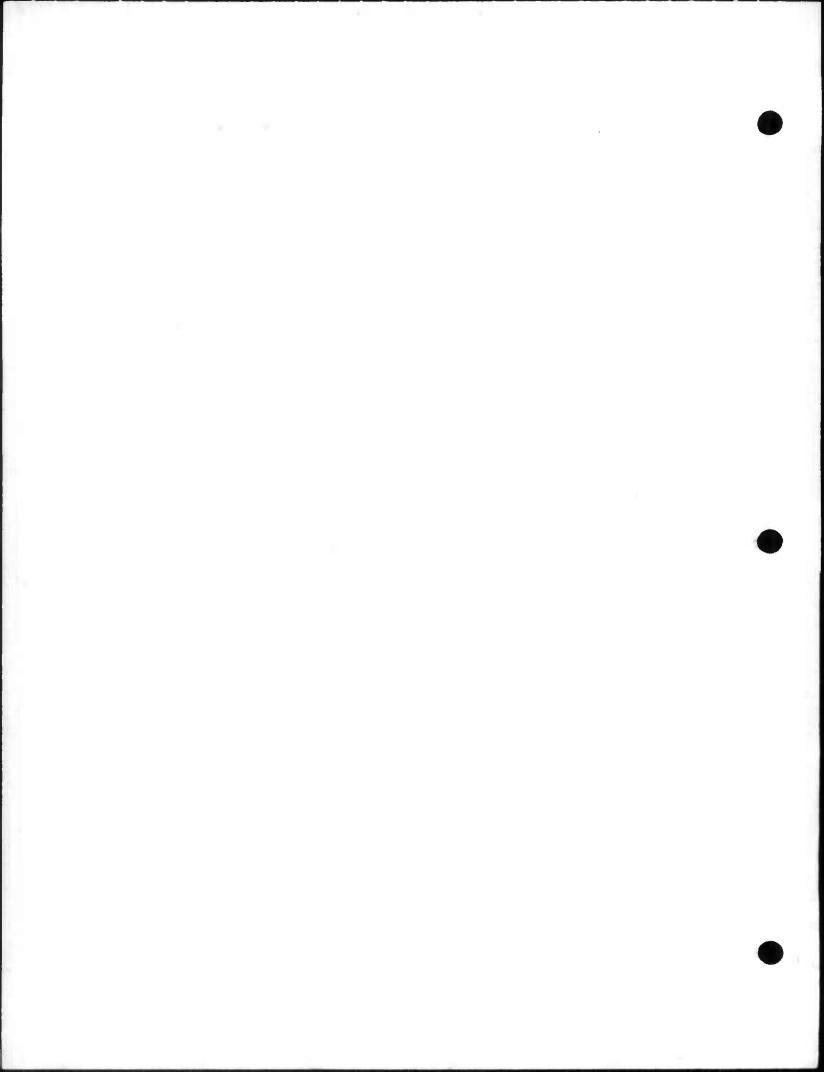
MONTGOMERY

10g. CITIZEN OF WHAT COUNTRY?

WHITE

1:40 A

DHMH-16 Rev 1/89

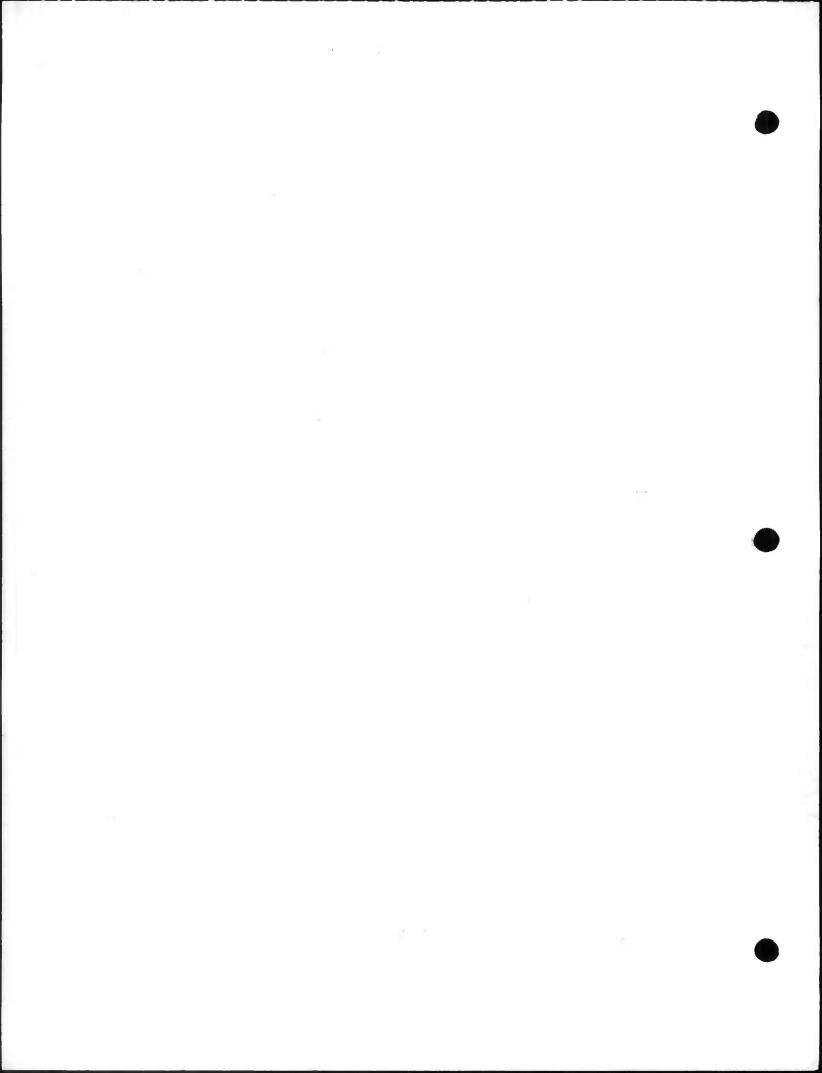


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| tained by the hospital or attending physician. | should be detached for use as the burlat-transit permit. Pages 1.2.3 should | | tifled at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narming Pages 1 2 3 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

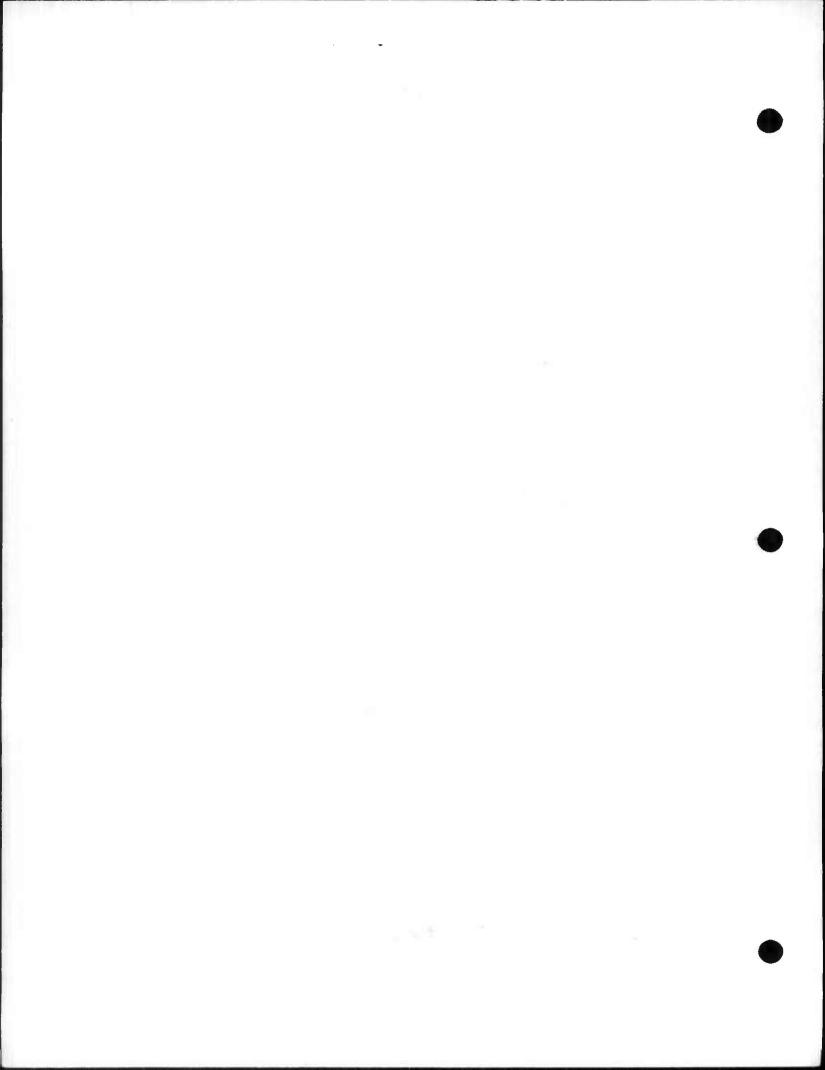
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | | HYGIENE REG. NO. | | |
|------------------|--------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|-----------------------|---------------------------------------|-------------------------|-----------------------------|----------------|------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | DEATH | | 3. TIME OF DEATH |
| | | MILDRED L | OUISE (| CARTER | | AUG. | 2.1 a | 1995 | 3 13/pm H |
| | 010 00 000 | | n yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF (Month, D | BIRTN | 8. BIR | THPLACE (State or Foreign |
| | 213-03-9687 | 1 M 2 X F | 9 2 YRS. | MONTHS DAYS | HOURS MIN. | 04/2 | 3/03 | M a | ryland |
| | Sa. FACILITY NAME (If not institution, give stre | net and number) | | 9b. CITY, TOWN C | R LOCATION OF D | EATN | 90 | COUNTY OF | |
| P P | 104 Park Lane | | | Feder | alsbur | g | | Carol | ine |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY |
| H. | Maryland Ca: | roline | | , rount on about | Feder | a 1 s h u | ra | | LIMITS? |
| | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | arobu | | n. CITIZEN OF | WHAT COUNTRY? |
| ER/ | 104 Park Lan | ne | | | 216 | 3.2 | | | d States |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | | 13. WAS DEC | ENDENT OF NISPA | NIC ORIGIN? (S | Specify Yes or N | lo — 14. RA | CE — American Indian. |
| BY F | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | | II yes, sp | cify Cuben, Mexico 2 (2) NO Specif | in, Puerto Rice | n, atc.) | Ble | ick, While, etc. |
| | | | | | | | | | White |
| COMPLETED | 15. OECEDENT'S EDUCA (Specify only highest grade of | ompleted) | 16a, DECEDENT'S I (Give kind of w life, Do NOT use | ork done during ma | N st of working | 16b. KH | ND OF BUSINES | SS/INDUSTRY | |
| 길 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | & Oper | ator | Su | nshine | Lau | ndry |
| M | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | |
| | | alter Coul | bourne | | 18. MOTHER'S NA | a Stei | | eme) | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | | AOORESS (Street e | nd Number or Rural | | | ata Zin Code) | |
| 2 | Carol Ann Shaw | | 5615 | | e., Hya | | | | 0792 |
| | 20s. METHOD OF DISPOSITION | 20b. | PLACE AND DATE O | | | | 20c. LOCATIO | | |
| | 1 Remov | 001110 | nity-Wa | | on Cem | 24 | Hur | lock, | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | | 22. NAME AN | D ADDRESS OF FA | | | | |
| | > musharlot & | show. M | gu. | Fram | ptom-Ha | wkins | S-Esko | w Fu | meral Home MD 21632 |
| | 23. PART I. Enter the diseases, or co | mplicetione that caused | the death. Do n | ot enter the mo | de of dyling, suc | h aa cardiac | or respireto | ry arrest. | MD Z163Z |
| | ahock, or heert fellure. Li IMMEDIATE CAUSE (Final | st only one ceuse on ee | ch line. | | | | 500 10.000 | | Interval Between Onset and Death |
| | disease or condition | C. KAR Good | can la | - Ni | 10113 | | | | |
| | reaulting in death) a. | OUE TO (OR AS A | CONSEQUENCE OF |): | . **) [| | | | 6 mo |
| Z | C b. | OUE TO (OR AS A I) DUE TO (OR AS A I) | Bowil 1 | Lym Pl | roms | | | | 1-1/249 |
| 5 | | DUE TO (OR AS A | CONSEQUENCE OF |): / | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or injury | 015 70 00 40 4 | | | | | | | |
| E | that initiated evente reaulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | |
| CERTIFICATION | d. | | | | | | | | |
| AL. | PART II. Other significant conditione | contributing to deeth bu | it not reaulting li | the underlying | ceuse given in | Part I. 24 | . WAS AN AUTO | OPSY 24 | b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| 8 | | | | | | 1 | YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | 1 TES 2 140 |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF | DEATH YE | S NO P | UNCERTAIL | V 🗆 | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 6. PLACE OF DEATI | OTHER: | | | | | |
| YSI | 1 YES 2 NO | 1 Inpatient 2 ER/Outpa | tlent 3 🗆 DOA | 4 - Nursing Nome | 5 Pasidence | 6 🗆 Other (Sp | pecify) | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIME INJU | JRY WO | RK? | 28d. DESCRI | BE HOW INJUR | Y OCCURED | |
| ВУ | 2 Accident Investigation | DA- DI ACE OF INTURY | | M 1 7 | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | 28s. PLACE OF INJURY - building, stc. (Specif | ··· At nome, larm, st y) | reet, factory, office | | City or To | ON (Street end Nown, Stete) | umber or Rural | Route Number, |
| COMPLET | 29e. CERTIFIER | | | | | - | | | |
| MPI | (Check only 1 CERTIFYING PNYSICI | AN: To the best of my knowle | | | | | | | No. Sec. Tool por Bill owners by I |
| 8 | | On the besis of examination | and/or investigation | , in my opinion, de | eath occured at the | time, date end | place, end due | lo the ceuse | (e) and menner ee stated. |
| BE | 295, SIGNATURE AND TITLE OF CERTIFIER | 5/// | | | 29c. LICENSE NUR | MBER | 290 | , DATE SIGNE | O (Month, Day, Year) |
| 2 | DE NAME AND ADDRESS OF PERSON WHO | COMPLETED CHIPTE OF THE | 1 0 | Desert | 1251 | 166 | | 8/2 | 2/95 |
| 17 | / / / | | OU NO ME HIDOURNE | | n+ah | n 1 - 7 | | | |
| | 31. DATE FILED (Mornty, Day, 'Bar) | Seder, III | | 000 L | u c c n m a | n S L | п., Е | aston | , MD 21601 |
| | AUG 2 2 1995 | | or-hardell | | | | | | |



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| FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT | |
|-----------------------------|--------------|--------------------------------------------------|-------------------------------|
| 1. DECEDENT'S NAM GERTRI | | COLVIN | 2. DATE OF DEATH AUGUST 17 |
| 0-212211 | DITTIAN | COLVIN | ragast 17 |

| | | 1. DECEDENT'S NAME (Flist) GERTRUDE | | T = 1 1 = | | | (| COLV | TNI | DLA | 7 | 2. DATE OF DEATH | | 9 KEAR | . TIME OF DEATH |
|------------------------------------------------------------|---------------|-----------------------------------------------------------------------------|----------------------------|-----------------------------------------|------------------------|---------------|------------------|------------------|------------|------------------------|-------------|---------------------------------------------|---------------------|--------------|--------------------------------------------|
| | | 4. SOCIAL SECURITY NUME | BER | Lillian s. sex | 6. AGE (| 'In yrs. last | | IF UNDER | | IF UNDER | | 7. DATE OF BIRTN | | A RIRTHPI | 6:40 p _M |
| Pin | | 220-24-215 | | 1 🗆 M 2 🄼 F | 85 | | YRS. | MONTHS | DAYS | HOURS | MIN. | June 28 | | 0 °V'i': | rginia |
| 2, 3 should | CTOR | 99. FACILITY NAME (If not in Easton Men | noria. | treet and number) 1 Hospi | tal | | | | | n, M | | land | | bot. | TN |
| - - | ١ | RESIDENCE OF DEC | 10b. COUNTY | / | | | the CIT | Y, TOWN C | D LOCA | TION | | | | | |
| nit. Pages | DIREC | Maryland | Caro. | | | | | | | Mar | yla | nd | | | Od. INSIDE CITY LIMITS? YES 2 1 NO |
| it permit. | RAL | 100. STREET AND NUMBER 3239 Galla | ahar | Dood | | | | | 0.00 | J. ZIP COD | | | | | AT COUNTRY? |
| 020 physician. burial-transit | FUNER | 11. MARITAL STATUS | igner | 12. WAS DECEDEN | IT EVED IN | III ADM | IED. | 12.7 | | 2165 | | IC ORIGIN? (Specify | US | | |
| 215-0020 attending physician. ise as the burial-tran | ₽ | 1 Never Married 2 3 Widowed 4 Divo | | FORCES? 1 | YES | 2 NO | 0 | _ ' | t yes, sp | pecify Cuba 3 2 XNO | in, Maxicai | n, Puerlo Rican, atc.) | es or No. | | - American Indian, White, atc. White |
| | TED | 15. DEC (Specify only | EDENT'S EDU | CATION completed) | | (GM | e kind of v | USUAL O | | ON ost of working | na | 166. KIND OF E | USINESS/INC | DUSTRY | |
| AND 21 he hospital or detached for u | MPLET | 6 Years (0 | 1-12) | College (1-4 or 5 | +) | Ho. E | zie | e retired.) | | | | Insula | ator | Prod | uction |
| 4 5 9 | COMP | 17. FATHER'S NAME (First, M | | Ton Voc | | | | | | | | ME (First, Middle, Maid | | | |
| | | Thomas Je | | son kee | ner | 196 | MAILING | ADDRESS | (Ptunet a | | | Elizabe | | | son |
| E, MAR y be retained age 5 should | | rances Ste | evens | | | | | | | | | ad Pres | | | 21655 |
| | | 20a. METHOD OF DISPOSITI | n 3 🗆 Reme | oval from Stata | cem | PLACE AN | atory or of | ther place! | | | | 1 | OCATION — | | |
| | | 21. SIGNATURE OF FUNERAL | | ENSEE | - 7 | en i | lave | | | | | 18-19 G | | | |
| 4 8 € | | > Mul | all | 1. Polos | ni | 2 | | [2] | L 6 | $N \cdot M$ | lain | awkins-1 | deral | sbur | A·21555 g, Md |
| hours after of in by the or removal | | | eart isilure. | complications that List only one cau | it caused ise on es | the dea | th. Do n | ot enter | the mo | ode of dy | ing, suct | as cardiac or res | piratory arr | est, | Approximate Interval Between |
| Ation. | | IMMEDIATE CAUSE (Fin disease or condition | ol | Re | × 0 | Fra | Low | , 5 | | lur | 0 | | | | 3krs |
| resulting in death) DUE TO (OR AS A CONSEQUENCE OFF) | | | | | | 4 | (A) | 101 | | | | | 3473 | | |
| UX 68/16 be executed ician and comrior to burial, | | Sequentially list conditi | ons, | DUE TO | OR AS A | 0 | IFNOT OF | | | | _ | | | | |
| or t or | CAT | If any, leading to immed cause. Enter UNDERLY | NG | | (011 745 74 | CONSEQU | JENCE OF | J. | | | | | | | |
| certificate ding physical sygiene pri | CERTIFICATION | CAUSE (Disease or Inju- that initiated events resulting in death) LAS | | DUE TO | (OR AS A | CONSEGU | JENCE OF | 7): | | | | | | | - |
| 1 5 5 6 | | Toodking in death) C/G | | 1 | | | | | | | | | | | |
| | i | PART II. Other significa | nt condition | . 1 | | 4 | | | | g cause g | given in I | Part I. 24a. WAS / | N AUTOPSY ORMED? | | ERE AUTOPSY FINDINGS |
| uires that signed by Health and | | 319 | 5 M | 7. | owe | 1 | 069 | stru | CT | 700 | | 1 YES | | C | OMPLETION OF CAUSE F DEATH? |
| 5 5 5 4 | W | DID TOBACCO U | SECONTI | A | LISE O | E DEAT | H VE | c Ma | 10 F | 1 LING | EDTAIN | | , | 1 | YES 2 NO |
| 4 9 4 6 | | 25. WAS CASE REFERRED TO EXAMINER? | | | | 26. PLACE | | | |] OIAC | ERTAIN | 101 | | | |
| SICIAN: The certificate he the State (| 1 (7) | 1 TYES 2 NO | | HOSPITAL: | ER/Outpe | atlent 3 | DOA | OTHER 4 Num | | ne 5 🗆 Ra | sidence | 8 Other (Specify) | | | |
| D F SE | | | Pending nveatigation | 28a. DATE OF (Month, D | INJURY lay, Year) | | 28b. TIME INJ | E OF URY M | | URY AT DRK? YES 2 | € NO | 28d. DESCRIBE HOW | INJURY OCC | CURED | |
| DR ATTENDING FOR DIRECTOR: After thours after death | TED | | Could not be determined | 28e. PLACE O building, | etc. (Speci | — At hom | e, term, s | treet, tecto | ory, offic | • | | 28t. LOCATION (Stree City or Town, Stell | t and Number e) | or Rural Rou | te Number, |
| | IPLET | | | | | | | | | | | to the cause(a) and m | | | |
| - co | 1 45 1 | | | | xamination | and/or Im | ve atigation | n, In my o | pinion, d | leath occur | ed at the t | lime, data and place, | and due to th | e cause(s) a | nd manner as stated. |
| TO THE HOSPI TO THE FUNEI TO FILE WITHIN | | 296. SIGNATURE AND TITLE | 160 | whe | > | 1 | 10 | | | 29c. LICE | 369 | BER 9 | 29d, DATE | SIGNED (M | lonth, Day, Year) |
| | | Dr. Susan | | ifer M | | | | | ımar | n's | Lane | Eastor | , M. | D. 2 | 1601 |
| | | 31. DATE FILED (Month, Day, 1 AUG 2 | | | | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the foath. Page 6 may be retained by the hospital or attending physician.

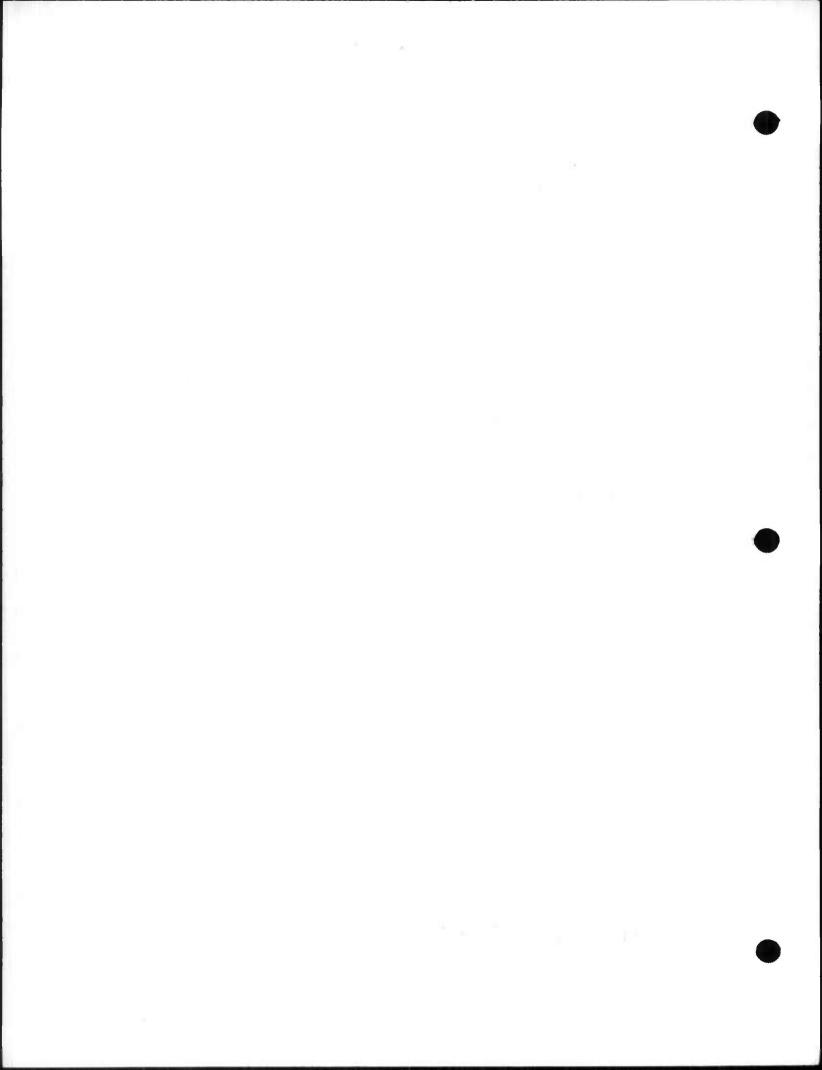
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 . STATE

| _ | REGISTRAR | CERTIFIC | ATE OF | DEATH | REG. NO | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------|-----------------------------|-----------------------------------------------|-------------------------|------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | 2. DATE OF DEATH MONTH D | AY YEAR | 3. TIME OF DEATH |
| | ELIZEBETH C. CARAVI | | | | JÜLY 20 | | |
| | 091-01-8481 1 □ M 2 K F 83 | | DAYS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) NOV. 14, | Cou | NTHPLACE (State or Foreign Intry) NEW JERSEY |
| | Se. FACILITY NAME (If not institution, give street and number) | 9 | b. CITY, TOWN | OR LOCATION OF DI | | 9c. COUNTY OF | |
| DIRECTOR | 25932 GOOSE NECK ROAD | | ROY | AL OAK | | TALBO | OT |
| HE | 10e. STATE 10b. COUNTY | 10c. CITY, 1 | TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? |
| | FLORIDA PALM BEACH | LUOS | | M BEACH | | | 1X YES 2 NO |
| FUNERAL | 10s. STREET AND NUMBER | 206 | 19 | of. ZIP CODE | | | F WHAT COUNTRY? |
| 2 | 4001 S. OCEAN BLVD., APT. | | 13 WAS DE | 33480 | IIC ORIGIN? (Specify Ye | USZ | |
| BY FI | 11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2, IF YES, GIVE WAR OR DATES | | If yes, s | | n, Puerto Rican, etc.) | 81 | ACE — American Indian, ack, White, etc. |
| 8 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | DECEDENT'S US | UAL OCCUPAT | ON | 16b. KIND OF BU | SINESS/INDUSTRY | , |
| | Elementary/Secondary (0-12) College (1-4 or 5+) | (Give kind of word life. Do NOT use n | etired.) | ost of worlding | OF THE | | |
| COMPLETED | 12 17. FATHER'S NAME (First, Middle, Last) | HOMEMA | KER | | OWN | | |
| | FRANCIS STARK | | | LOUI | ME (First, Middle, Malden SE PET | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | | | Route Number, City or Tow | | |
| - | STEPHEN A. CARAVELLO | 678 33 | RD AV | E., SAN | FRANCIS | CO, CA | 94121 |
| | | ISBURY | | | 7-21 SAL | CATION — City or ISBURY | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 0 | 22. NAME A | ND ADDRESS OF FA | ERAL HOM | E D A | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | _ (F.S.F. | 200 | | RISON ST | | |
| | 23. PART I. Enter the diseases, Dr complications that caused the shock, Dr heart failure. List only one ceuse on each | death. Do not | enter the m | ode of dying, suc | h aa cardlac or reap | iratory arrest, | Approximate |
| | IMMEDIATE CAUSE (Finel | | | | | | Onset and Death |
| | resulting in death) a. Out to (OR AS A COR | | | | | | 9 months |
| - 1 | He part t | SECUENCE OF | · · | fection | | | 34.0015 |
| ᅙ | Sequentially list conditions, if any, leading to immediate | SEQUENCE OF): | - 10 | | | | Jack , |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | |
| | that initiated events resulting in death) LAST | ISEQUENCE OF): | | | | | |
| 핑 | d | | | | | | |
| EDICAL | PART II. Other algorificant conditions contributing to deeth but n | | he underlyin | g ceuse given in | Part I. 24a. WAS AN PERFOR | | 4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| ă | C 50 graga i curi a | 7 | | | 1 TYES 2 | E NO | OF DEATH? |
| 2 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF D | FATH VES | ПИОБ | LINICEDTAIN | | | 1 TYES 2 TYNO |
| ÄÄ | 25. WAS CASE REFERRED TO MEDICAL 25. P | LACE OF DEATH | | | 101 | | |
| PHYSICIAN: | EXAMINER? 1 VES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatien | | THER: | ne 5 D Residence | 6 Other (Specify) | | |
| F | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Veer) | 28b. TIME O | | JURY AT | 28d. DESCRIBE HOW I | NJURY OCCURED | |
| à | 2 Accident Investigation | | M 1 🗆 | | | | |
| COMPLETED | 3 Suicide 6 Could not be determined 20e. PLACE OF INJURY — A building, atc. (Specify) | t home, farm, stre | et, fectory, offic | 20 | 281. LOCATION (Street of City or Town, State) | and Number or Rura | Il Route Number, |
| 7 | 29e. CERTIFIER (Check only (Ch | , death occurred a | t the time, date | end place, and due | to the cause(s) and mar | nner as stated. | |
| Š I | one) 2 MEDICAL EXAMINER: On the basis of exemination and | /or investigation, i | n my opinion, | feath occured at the | lime, date and place, an | d due to the cause | e(s) and manner as stated. |
| BE | 296. SIGNAPORE AND TITLE OF CERTIFIER | A A | N | 29c. LICENSE NUN | IBER - | 294. DATE SIDNE | D (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (| 101 | <u> </u> | 046 | 1/65 | - / | 21/95 |
| | TIMOTHY DENW | EW 27) (Type, Pri | 607 | Dutchn | ons Car | e Eas | iton MD |
| | 31. DATE FILED WONTH, Day, Young State of State | roball | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing an attended in the funeral director, page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

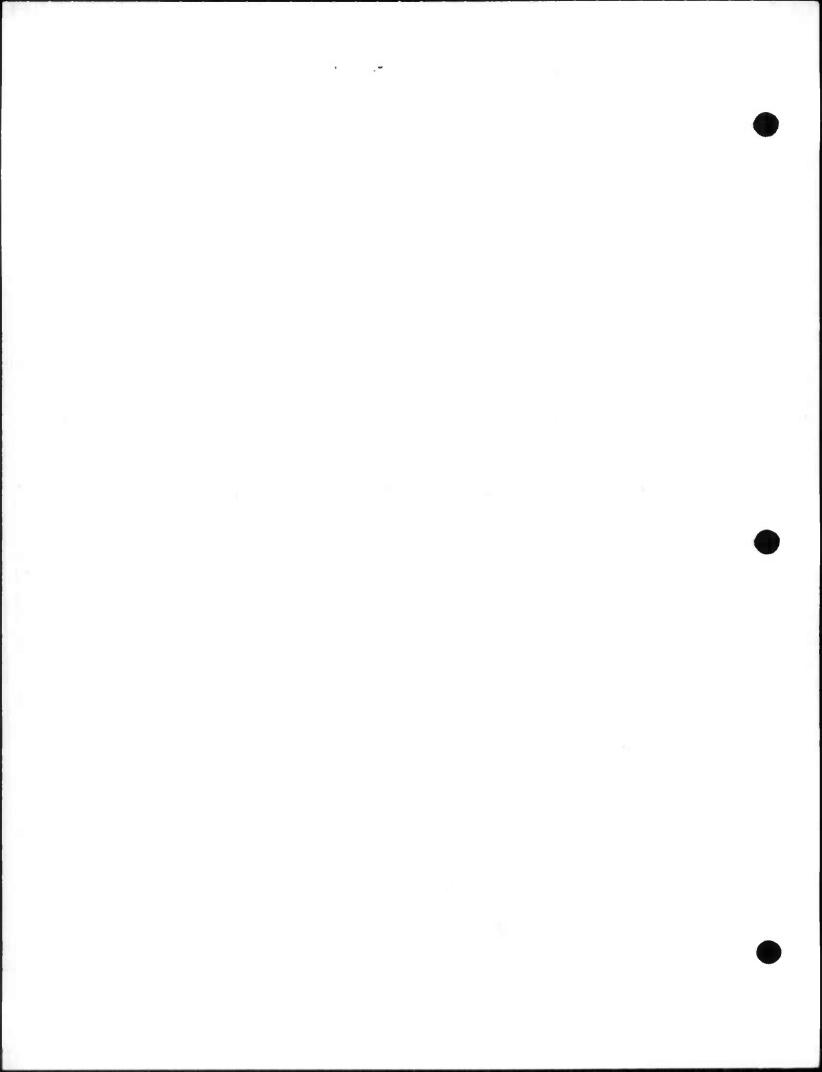
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | | REGISTRAR | | C | ERITER | CAIL | IF DEATH | REG. NO. | | | |
|------------------|---------------|-----------------------------------------------------------------|---------------------------------------------------|--------------------|----------------|-----------------------------------|--------------------------------|-------------------------------------------------|----------------|-------------|--------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) JOSHUA CHRI | CMV CONNI | מי | TD | | | 2. DATE OF DEATH | 5,19 | YEAR | 3. TIME OF DEATH |
| | | JOSHUA CHRI 4. SOCIAL SECURITY NUMBER | | (In yrs. las | JR. | IF UNDER 1 YEA | IR IF UNDER 24 HRS. | JULY 2. | 5,19 | | 7:56 PM M |
| | | 221-18-3280 Ba. FACILITY NAME (If not institution, give st | iX M 2 □ F | 78 | YRS. | AONTHS DAY | B HOURS MIN. | (Month, Day, Year) FEB.1,1 | | DEI | AWARE |
| | стов | 28165 CANTERBU | | | | EAS | N OR LOCATION OF DI | EATN | | ALBC | |
| | E C | 10e. STATE 10b. COUNTY | | | 10c CITY | TOWN OR LO | CATION | | | | 404 101010 01714 |
| | L DIRE | MARYLAND TA | LBOT | | | EASTO | N | | | | 10d. INSIDE CITY LIMITS? 1 YES 2X NO |
| | FUNERAL | 28165 CANTERBU | DV COUDE | | | | 10f. ZIP CODE | | | | HAT COUNTRY? |
| | × I | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. A.B | MED | 12 148 0 | 21601 | NIC ORIGIN? (Specify Yea | | SA | |
| | | 1 Never Married 2 X Married | FORCES? 1 Y YES | 2 N | | If yes | , specify Cuban, Mexica | in, Puerto Rican, atc.) | W NO- | Black, | — American Indian, White, etc. |
| | BY | 3 Widowed 4 Divorced | WW II | DATES | | '' | YES 2X NO Specif | у: | | Specify | WHITE |
| | ETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (G | ve kind of wo | SUAL OCCUP | ATION most of working | 16b. KIND OF BUS | SINESS/INC | DUSTRY | |
| | 2 | Elementary/Secondary (0-12) | College (1-4 or 8 +) 4 | | emic: | | gineer | Che | mica | 1 | |
| once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | CII | CINTO | 41 Di | | ME (First, Middle, Melden | | | |
| 75 | BE C | Joshua Chri | sty Conne | er | | | Edna | Louise | Smit | :h | |
| notified | 2 | Jacqueline R. | Conner | 2 | 8165 | Cant | erbury S | Aoute Number, City or Town | on, State, Zip | MD Code) | 21601 |
| must be | | 20e. METHOD OR DISPOSITION 1 | oval from State ce | b. PLACE A | ND DATE OF | DISPOSITION or placed V Cre | matory | 1 | | City or Tow | m, State , Maryland |
| niner | | 21. SIGNATURE OF FUNERAL SERVICE LIC | | 1 01 | _ ^ | | | ral Home | | | - |
| exar | | MY . L. New | mane | CH | = 5.P | | | | , Ea | stor | n,MD 21601 |
| medical examiner | | 23. PART I. Enter the diseases, or c shock, or heert failure. I | omplications that cause List only one cause on | d the de | ath. Do no | t anter the | mode of dying, auc | h aa cardiac or reapi | ratory arr | eat, | Approximate Interval Between |
| the | | IMMEDIATE CAUSE (Final disease or condition | motori | 0- | ado | UARA | | 0 3/ 101 | Tour | 11 | Onset and Death |
| vent | | resulting in death) | metasto DUE TO (OR AS | A CONSEC | DUENCE OF | 1 1 | 1 | 6 | Car | | Rai Mit |
| traumatic event, | S S | Sequentially list conditions, | Recentreu | to | well | leon | vel obs | (vullion | | | May 1995 |
| taca. | TA. | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEC | LASA | | | | | | |
| or other | 띮 | CAUSE (Disease or Injury that initiated events | OUE TO (OR AS | A CONSEC | UENCE OF): | | | | | | |
| | CERTIFICATION | resulting in death) LAST | ı | | | | | | | | |
| ajury | | PART II. Other algolficant conditions | a contributing to death | but not n | eaulting in | the underly | ring cause given in | Part I. 24s. WAS AN | AUTOPRV | 246 | WERE AUTOPSY FINDINGS |
| any injury, | EDICAL | melanoma | | | | | | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 2 2 | MEC | | 0 | | | | | 1 🗆 YES 2 | Trav | | OF DEATH? 1 TES 2 NO |
| 23 shor | | DID TOBACCO USE CONTR | RIBUTE TO CAUSE O | | | | | V 🗊 | | | |
| Item : | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | - | (Check only o | ne) | | | | |
| 6 9 | ĭ. | 1 YES 2 NO 27. MANNER OF DEATH | 1 Dipetient 2 ER/Out | tpatient 3 | DOA 4 | ☐ Nursing N | ome 5 Residence | 6 Other (Specify) | | | |
| marked, | ВУ РН | 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | 26b. TIME (| TY Y | INJURY AT WORK? YES 2 NO | 28d. DESCRIBE NOW IN | IJURY OCC | CURED | |
| 28 is | ETED (| 3 Suicide 6 Could not be determined | 28e. PLACE OF INJUR building, etc. (Spe | Y At hor ecify) | ne, farm, etre | et, fectory, o | Mice | 26f. LOCATION (Street a City or Town, Stete) | nd Number | or Rural Ro | ute Number, |
| item item | P.E. | 290. CERTIFIER (Check only | CIAN: To the best of my know | vledge, des | th occurred | at the time, o | ate end place, end due | to the cause(s) and men | ner es stat | ad. | |
| MPORTANT: H | COMPL | | 3: On the beels of exemination | | | | | | | | end manner ee stated. |
| ATA | w i | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | | 29c. LICENSE NUM | IBER | 29d. DATE | E SIGNED (| Month, Day, Year) |
| M M | 9 | SMA | Syed A | li, | M.D. | | D460 | 20 | ▶ 7 | 1261 | 95. |
| | - | 30. NAME AND ADDRESS OF PERSON WHO 506 Idlewild | A 11 | | A | | 0.16 | v | | - | |
| | - | 31. DATE FINED (Nonto DEL MAIO | | | tou | MD | 21601. | | | | |
| | | 31. DATE FINEDICHOND 09. 1995 | Jelan White | Marial | V, | | | | | | |



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| A ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. | RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | urs after death with the State Dept, of Health and Mental Hygiene prior to burfal, cremation, or removal. | m 28 is marked, or item 23 shows any fajury, or other traumatic event, the medical examiner must be notified at once. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSIC | TO THE FUNERAL DIRECTOR: After this | be filed within 72 hours after death with | MPORTANT: If Item 28 Is marked, |
| TO THE H | TO THE FL | be filed w | IMPORTA |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR NORMAN F. COOK, SR. 1658 23, ULY 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | | | F UNDER t YEAR | | | F UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign 07/22/06 DAYS HOURS 89 YRS. 1 X M 2 F 218-30-0822 Maryland 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Atlantic General Hospital DIRECTOR Berlin Worchester RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Caroline Federalsburg 1 YES 27 100 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4680 Laurel Grove Road 21632 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 ND Specify White BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture 8th 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Ferdinand Cook Cora Nichols BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Norman F. Cook, Jr. 34 Pine Rd., Selbyville, DE 19975 20s. METHOD OF DISPOSITION
1 X Burisl 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Crest Cemetery 4 Donation 6 Other (Specify) 26 Federalsburg, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY - Eskow Framptom-Hawkins-Eskow Funeral Home ▶ Mular PO Box 43, Federalsburg, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** disease or condition overwholm resulting in death) DUE TO (OR AS A CONSEQUENCE OF Preumones CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF). if any, leading to immediate UTI cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO Subdured hemstoma COMPLETION OF CAUSE OF DEATH? 1 - YES 2 000 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HØSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TYES 2 NO Inpatient 2 ER/Outpatient 3 DOA 27. MANNER DF DEATH 28s. DATE DF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined ETED. 4 Homicide 29s. CERTIFIER Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placs, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 23 sie Julens H43617 MV 9

11220 BERUCKAMORD

30. NAME AND ADDRESS OF PERSON WHO/COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

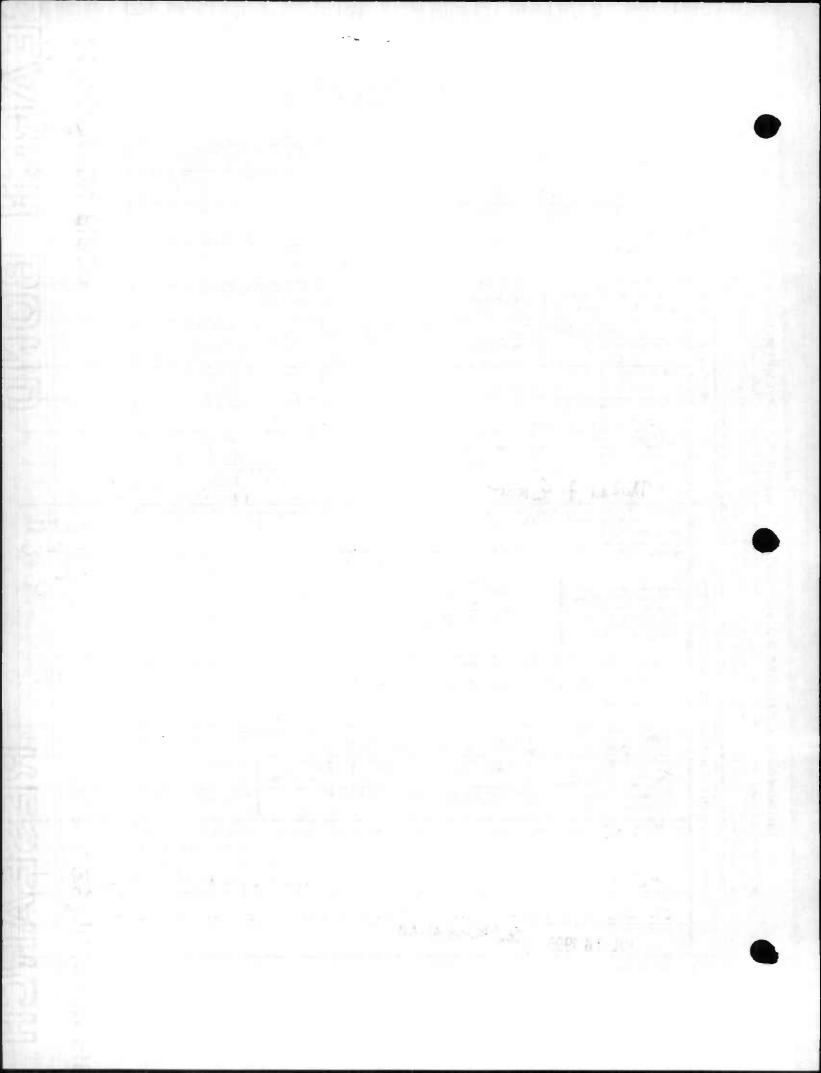
32. REGISTRAR'S SIGNATURE NOW

BR. SLOTT Sweens

JUL 26 1995

31. DATE FILED (Month, Day, Year)

BENUNNO ZIRI



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|-------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| RICHORD | e as the | |
| incate be executed with | nd completely filled in by the funeral director, page 5 should be detached for use as the burial-trans | |
| statiliza by u | should be o | |
| lay the l | page 5 | |
| مراه م | director, | |
| חבמתו. ו | funeral | |
| Hall Gills | in by the | r removal |
| | ely filled | ation, o |
| TION MILE | сотрієт | and Mental Hygiene prior to burial, cremation, or remo |
| ב מאמרו | an and | r to bu |
| JINCARE D | physici | ene prio |
| IN THE DEALH CELLING | by the attending physician and | ntal Hygi |
| n auc n | by the | nd Me |
| 3 | - | 40 |

BALTIMORE, MARYLAND 21215-0020

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BOX

P.O. 1

DIVISION OF VITAL RECORDS.

THE HOSPITAL OF THE FUNERAL OF THE WITHIN 72 has INDRITANT: It IN

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| Godel Collingate of weeding min. | trending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | other traumatic event, the medical examiner must be notified at once. |
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| חב משפרתופת אווו | cian and completely | or to burial, cremati | aumatic event, 1 |
| e neam cerminam | he attending physical | Mental Hygiene pr | jury, or other t |
| de leguines men mi | been signed by t | nt. of Health and | item 28 is marked, or item 23 shows any Injury, or other |
| TOTAL THE IN | ils certificate has | th the State Dep | d, or Hem 23 |
| OH ALLENDING PRI | CTOR: After this | after death wit | 28 is marke |
| 5 | OIRE | hours | tem |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE 1 -CERTIFICATE OF DEATH REGISTRAR REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2, DATE OF DEATH 3. TIME OF DEATN YEAR MICHAEL CHIESA AUGUST 1995 4:15 24 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. March 7, 1968 DAYS 577-88-7056 HOURS MONTHS 1 X M 2 | F 27 YRS. Washington DC Sa. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF OFATN 9b, CITY, TOWN OR LOCATION OF OEATN DIRECTOR 3200 BROWN STATION ROAD UPPER MARLBORO PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNTY 19¢. CITY. TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 10a. STATE 1 YES 2 XNO Prince George's Upper Marlboro Maryland FUNERAL 100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? United States 20772 13450 Lord Dumbore Road 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YO 14. RACE — American Indian, Black, White, etc. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yas or No If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify Specify: BY 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementery/Secondary (0-12) College (1-4 or 5+) Hyattsville City Police Police Officer 12 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Suman Heidi Zepeda Chiesa Michael BE 196. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13450 Lord Dumbore Road, Upper Marlboro, Md 20772 19a. INFORMANT'S NAME (Type/Print) 9 Lisa Chiesa (Wife) 20a METNOD OF DISPOSITION
1 A Burlal 2 Cremation 3 Removal from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of Aug 26, 1995) 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Resurrection Cemetery Clinton, Maryland 21. SIGNATURE OF FUNERAL SHIPPICE DISCHBEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735 23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart fellure. List only one ceuse on each line. Approximate Interval Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition Oteple Yu W wites reaulting in death) DUE TO (OR AS A CONSEQUENCE OF); CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL PERFORMED? AMERICAN PRIOR TO COMPLETION OF CAUSE OF OEATN? 1 YES 2 NO TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: XXYES 2 NO 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence SY Other (Specify) ROADWAY 286. DESCRIBE HOW MALINY OCCUPIED . Franch 27. MANNER OF CEATN 28s. DATE OF INJURY 28c, INJURY AT WORK? 28b. TIME OF INJURY 1 Netural
2 Apoldent 25a. PLACE OF INJURY — At home, tgrm, street, factory, office building, etc. (Specify) 5 Pending 1 YES BY Investigation City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Nomicide woodles 3200 Heck homed tehon 29a. CERTIFIER 1 Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as straight occurred. Man 10 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, data and place, TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 17 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE KIR ▶AUGUST 24,1995 O.C.M.E mer

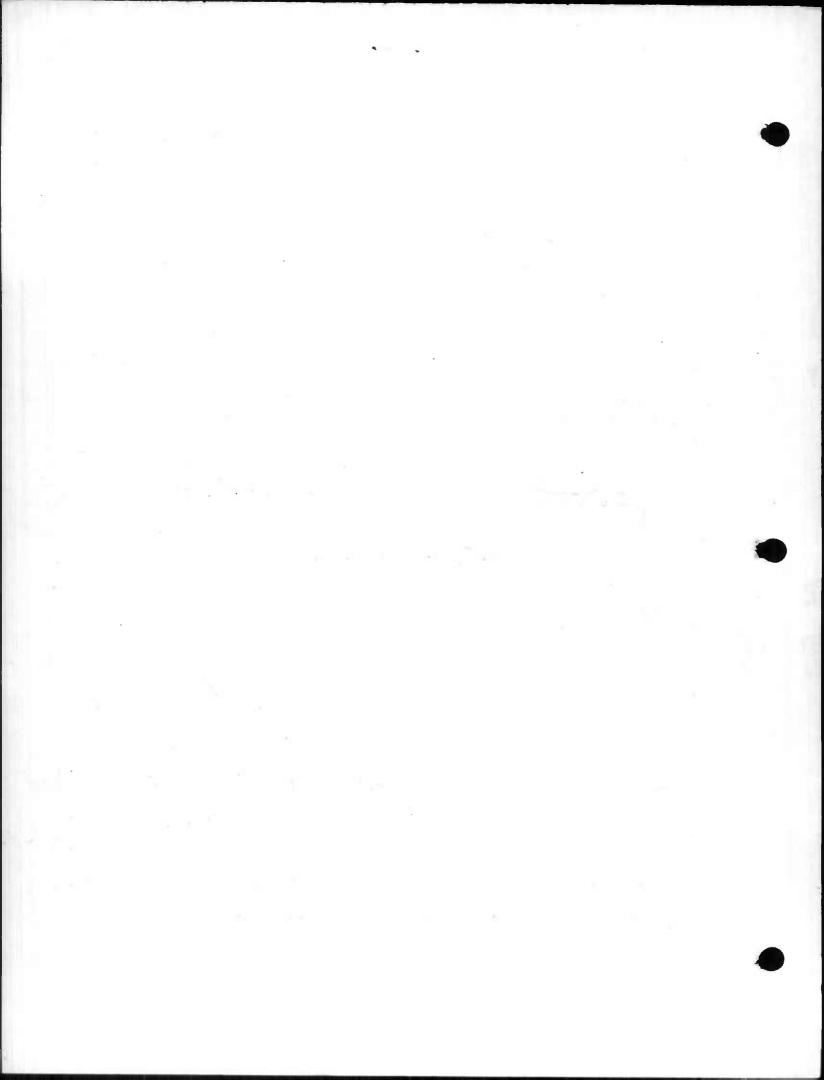
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

32 HEATRANG SIGNATURE PARAMETERS OF MANUALLY AUG 2 9 1995

HE POORE MIKIN

31. DATE FILEO (Month, Day, Year)

~



3. TIME OF DEATH

AM

6:16

10d. INSIDE CITY

1 X YES 2 NO

WHITTE

8. BIRTNPLACE (State or Foreign

MARYLAND

MONTGOMERY

U.S.A.

Specify:

WERER

14. RACE — American Indian, Black, White, etc.

etained by the hospital or attending physician. **IMORE, MARYLAND 21215-0020** 6 may Pages 1, 2, 3 should

permit

director, page 5 should be detached for use as the burial-transit

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

notified

9

must

CERTIFICATION

MEDICAL

PHYSICIAN:

В

4 Nomicide

COMPLETED

BE

2

INTINION OF VITAL

| BALLIM | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct be filled within 72 hours after death with the State Dent, of Health and Mental Motiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner is |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| 00/00 400 | ate be executed with | lysician and completed prior to burial, cre- | r traumatic even |
| CITIZENE NECONDS, F.C. BOX 66760 | hat the death certific | d by the attending ph and Mental Hygiene | ny injury, or other |
| 7720 76 | d: The law requires t | cate has been signe State Dept. of Health | item 23 shows a |
| | TENDING PHYSICIAN | TOR: After this certifi- ifter death with the S | 8 is marked, or |
| | THE HOSPITAL OR A | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filled within 72 hours after death with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal. | MPORTANT: If Item |
| | | | _ |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH RANDALL WESLEY CREWS AUGUST 18. 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 M 2 F DAYS HOURS 219-48-3820 JULY 12 1961 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 1120 CROWFOOT LA. SILVER SPRING RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION MD. MONTGOMERY SILVER SPRING ton, STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1120 CROWFOOT LA. 20904 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR OATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Mexican, Puerto Rican, atc.) 11. MARITAL STATUS 1 Never Married 2 Married 1 YES ZY NO Specify: 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) PLANT RESEARCH CROP GENETICS INC. 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surname) THOMAS W. CREWS DELORES J. 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS W. CREWS SAME AS ITEM 20b PLACE AND GATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE CHAMBERS CREMATORY 8/19 RIVERDALE, 21. SIGNATURE OF FUNERAL SERVICE LICEMSET 22. NAME AND AODRESS OF FACILITY M00091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition HIV resulting in desth) OUE TO (OR AS A CONSEQUENCE OF): ogressive neurologic deterioration Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Jastina CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 XES 2 1 NO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 | NO

Approximate

interval Bety

Onset and Death

6 mont

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO MUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 Residence 8 - Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED

27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be

determined

28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, atreet, factory, offica building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

8/18/95

t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and placs, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30, NAME AND ADD PERSON WNO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

LINDA L. LEWIS, M.D.

9000 ROCKVILLE PIKE, BETHESDA, MD 20892

#5963

32. REGISTRAR'S SIGNATURE Tulia Davalson Rawall

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF M | | DEPAR | | | | | MENTAL HYGIE | | | | | |
|---------------|------------------------------------------------------------------------------------------|-----------------------------------------|---------------------|---------------------|--------------|------------|-------------------|------------|----------------------------------------|-------------|--------------|--------------------------------------------|--|--|
| 3 | 1. DECEDENT'S NAME (First, Middle, Last) | - | | | | | | | 2. DATE OF DEATH | |] | 3. TIME OF DEATH | | |
| | Evie M. | Cohen | | | | | | | August 13 | , 199 | 5 | 10:00 A M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. las | | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Dey, Year) | | | IPLACE (State or Foreign | | |
| | 217-46-6584 | 1 M 2 A F | 48 | YRS. | MONTHS | DAYS | HOURS | MIN. | May 13, 1 | 947 | | ington, D.C. | | |
| | 9a. FACILITY NAME (If not institution, give a | | | | | | R LOCATIO | ON OF DE | DEATH Bc. COUNTY OF DEATH | | | | | |
| OR | 2215 Kimball Plac | e | | | Sil | ver | Spri | ng | | Mon | tgom | ery | | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | v | | 100 017 | Y, TOWN (| 201001 | | | | | | | | |
| DIRECTOR | Maryland Montg | | | | ver | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| | 10a. STREET AND NUMBER | ome Ly | | DII | VCI | | . ZIP CODE | | | | | 1 Nes 2 No | | |
| FUNERAL | 2215 Kimball Plac | | | | | 100 | 209 | | | US | | VHAT COUNTRY? | | |
| N. | 11. MARITAL STATUS | 12. WAS DECEDENT | FVFR IN II S AR | MED | 12 | WHE DEC | | | IC ORIGIN? (Specify Y | | | | | |
| | 1 Never Married 2 K Merried | FORCES? 1 | VES 2 PA | 10 | 1.0 | If yes, sp | city Cuba | n, Mexican | , Puerto Rican, etc.) | or No- | Black | — Americen Indian, k, White, atc. | | |
| ВУ | 3 Widowed 4 Divorced | | AN ON DATES | | | 1 🗌 163 | 2 (2), NO | Specify. | | | Speci | nite | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | N et of workin | _ | 18b. KIND OF BI | JSINESS/INI | DUSTRY | | | |
| 91 | Elementary/Secondary (0-12) | College (1-4 or 5 + |) Iffe. | Do NOT us | se retired.) | | | v | | | | | | |
| MP | 12 | 2 | | Hair | Des | igne | r | | Hai | r Sal | on | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | ME (First, Middle, Maide | n Sumame) | | | | |
| BE | Chris Koutsoukos | | | | | | | | Cokinos | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | oute Number, City or To | | | 1 00010 | | |
| | Alan David Cohen | | | | | | | e, S1 | - | | | Land 20910 | | |
| - 5 | 20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Remote 4 Donation 6 Other (Specify) | oval from State | Norbe | MATERIAL CONTRACTOR | OF DISPOS | OT T | ne of | | 8/16 Oln | | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | SNSEE | Norbed | CK Me | | | | SE OF FAC | | | | neral Home | | |
| - 1 | 1000 | | | | 1 | 1800 | New | Ham | pshire Av | enue | | merar nome | | |
| | 111). 100 | | | | | | - | | , Marylan | | | | | |
| ı | 23. PART i. Enter the diseases, or of ahock, or heart failure. | omplications that List only one ceur | ceused the de | ath. Do r | ot enter | the mo | de of dyl | ng, such | as cardiac or resp | piratory an | reat, | Approximate Interval Between | | |
| | | 7.0 | | | | | | | | | | Onset and Death | | |
| l | resulting in death) | . Cardio | fulnin | ary | as | 7C5+ | | | | | | | | |
| | | DUE TO | OR AS A CONSEC | DUENCE OF | F): | | | | | | | | | |
| CERTIFICATION | | DUE TO | OR AS A CONSEC | DUENCE OF | 7 (| ance | 1 | - | | | | | | |
| Ă | If sny, lesding to immediate cause. Enter UNDERLYING | St | read to | hra | un | 1.0 | 1 \ | hom | 1 1.78 | ^ | | | | |
| Ē | CAUSE (Diseese or Injury that initiated events | DUE TO (| OR AS A CONSEC | UENCE OF | 7: | 1000 | 05 | Jone | e, 1, ve | | | + | | |
| F | resulting in death) LAST | d. | | | | | | | | | | | | |
| | PART II Other elgoificent condition | | d==4b_b_a_a_=a_ | 444 | | | | | | | | | | |
| NA | PART II. Other significent condition | ii contributing to (| death but not re | esulting | n the un | iderlying | cause g | iven in F | | RMED? | 24b. | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO | | |
| MEDIC | | | | | | | | | 1 YES | 2 NO | | OF DEATH? | | |
| Σ | DID TODA COO HEE CONT | | | | . = | | | | | | | 1 TYES 2 NO | | |
| AN | DID TOBACCO USE CONTE | KIBUTE TO CAL | | | | | UNC | ERTAIN | | | | | | |
| ᅙ | EXAMINER? | HOSPITAL: | | E OF DEAT | OTHER | ₹: | | | / | _ | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 1 Inpatient 2 I | | 28b, TIM | | 28c. INJU | | eldence 6 | 28d. DESCRIBE HOW | N HIEW OO | 011050 | | | |
| | 1 Natural 5 Pending | (Month, Da | | | URY | WOI | RK? | I NO | 28d. DESCHIBE HOW | INJUHY OC | CURED | | | |
| ă | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE OF | INJURY — At hor | me, farm, s | treet, lect | | | 100 | 261. LOCATION (Street | and Number | or Bruss S | Inustra Alusenhar | | |
| | 4 Homicide 6 Could not be determined | building, e | rtc. (Specify) | | , | | | | City or Town, State |) | or rioral ri | cole Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only | CIAN: To the heet of | mi knowladaa da | th armin | 4 -4 45 - 41 | - 4. | | | | A SHEW S | | | | |
| ğ | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | J | | | | | | | | |
| ᇤ | Jun FI | and Ho | ~ u | 11 | 1 | | 29c. LICE | NSE NUMI | EER 1 | 29d. DAT | | (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITEM | 127) (5 | Print | | ~ | . 17 | 401 | | 2/1 | 1/13 | | |
| | SUJAN HONIO | A 4 - | - | enc | | Uza | Shis | תלגו | 1.00 | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | 'S SIGNATURE | |) | | 5.7.0 | 0' | | | | | | |
| | AUG 21 1995 | Julia Daw | dear Rand | ell, | | | | | | | | | | |
| | .000 | () | | | | | | | | | | | | |

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

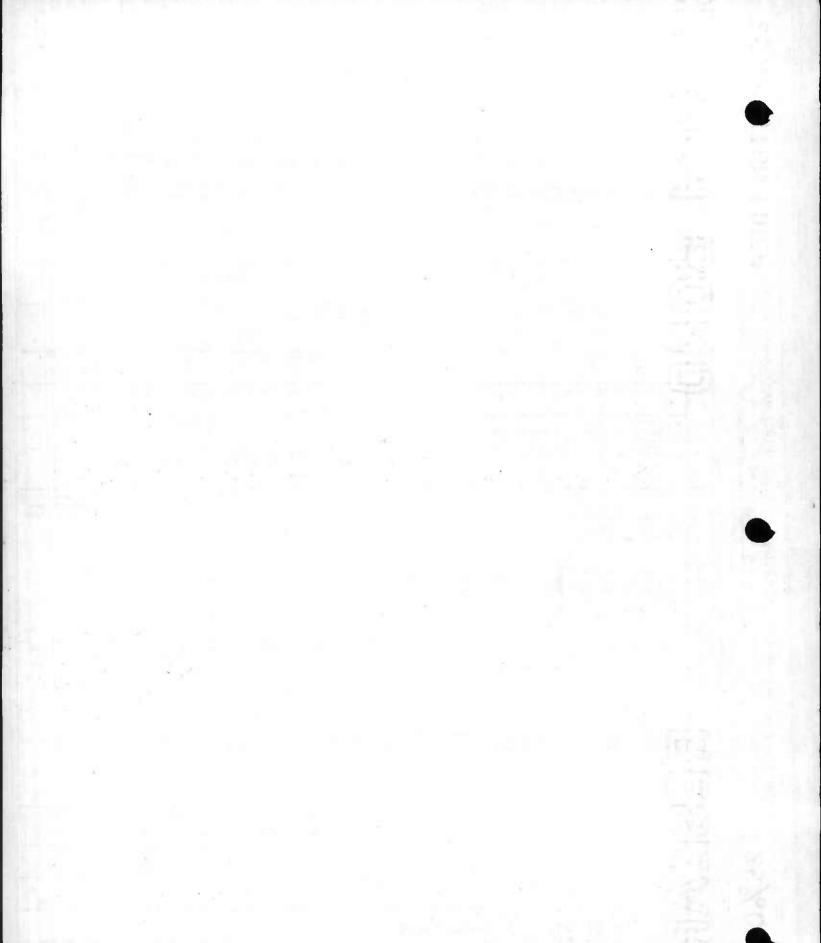
CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Lest)

2. DATE OF DEATH MONTH

AND MANYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REG. NO.

| | REGISTRAR | | | | CENTIL | ICALE | OF | DEA | III | | HEG. NO | | | |
|-------------|---------------------------------------------------|--------------------------|---------------------------|----------------|-------------------|----------------|--------------|-----------------|-------------|----------------|-----------------------------|---------------|-----------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, | , , | | | | | | | | 2. DATE O | F DEATH D | AY | YEAR | 3. TIME OF DEATH |
| 1 | | | Verne Cl | | | | | | | | ist 18 | 3, 19 | | 4:00 AM |
| 100 | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In yra | s. last birthday) | MONTHS 1 | YEAR DAYS | HOURS | MIN, | 7. DATE O | F BIRTH Day, Year) | | S. BIRTH | PLACE (State or Foreign |
| | 216-22-6543 | | 1 M 2 X F | 90 | YRS. | | | | | Feb. | 28, 1 | L905 | Mar | yland |
| _ | 9e. FACILITY NAME (If not ins | atitution, give : | street and number) | | | 9b. CITY, | TOWN | OR LOCAT | ION OF D | PEATH | | 9c. COU | NTY OF DE | EATH |
| 9 | Cumberland | | ng Home | | | | umk | perla | and | | | A | llega | any |
| ដួ | RESIDENCE OF DEC | 10b. COUNT | Y | | 10c CI | TY, TOWN OF | I LOCA | TION | | | | | | 10d. INSIDE CITY |
| DIRECTOR | Maryland | | | | | | | | | | | | | LIMITS? |
| | 10e, STREET AND NUMBER | MOI | tgomery | - | 1 1 | Rockvi | _ | H. ZIP COD | NE . | | | 10- 017 | TEN OF W | 1 YES 2 X NO |
| RAL | | Lara Da | | | | | 10 | | | | | | | |
| FUNER | 13204 Val | rey Dr | 12. WAS DECEDEN | T EVEN IN IL | 101150 | 40.11 | | 2085 | | NIC ORIGIN? | | | | States |
| BY FL | 1 Never Married 2 3 Widowed 4 Divo | | FORCES? 1 | YES 2 | X NO | H | yes, sp | pecify Cub | en, Mexico | an, Puerto Ri | can, etc.) | or No- | Black Specif | |
| ED E | 15 DEC! | EDENT'S EDU | ICATION . | 144 | . DECEDENT'S | I HEHAL OC | CHIDATA | - | | 100 | VIII 05 DI | | N LO TON | White |
| ETE | (Specify only | highest grade | completed) | | (Give kind of | work done di | uring mo | ost of work | ing | 100. | KIND OF BU | SINESS/INL | JUSTRY | |
| _ | Elementary/Secondary (0- | -12) | College (1-4 or 5 - |)) | | | | | | 100 | O T | 1 | | |
| COMP | 17. FATHER'S NAME (First, Mi | ciclia (ant) | | | Homen | laker | _ | 40.440 | | AME (First, Mi | Own H | | _ | |
| | Charles Cu | | ham | | | | | | | | | Surname) | | |
| BE | 19e. INFORMANT'S NAME (I) | | Italii | | 405 444 11 11 | 2 40000000 | (D4 | 4 | | Aoute Number | | | | |
| 2 | Betty Jane | | | | | | | | | | | | | 20050 |
| | 200 METHOD OF DISPOSITI | | | 205 81 6 | | | | | | | | Mary CATION - | | 20850 |
| | 1 🖾 Burlel 2 🗆 Crematio 4 🗆 Donation 5 🗆 Other | n 3 🗆 Rem | noval from State | cemeter | CEAND DATE | other place) | üğü | ist 2 | 22, 1 | 1995 | C: 1: | | | g, Maryland |
| | 21. SIGNATURE OF FUNERAL | | CENSEE AA | | 00831 | 22. N | AME A | ND ADDR | ESS OF FA | ACILITY | lott. | | | |
| | 7 h | an | 2m. 0/2 | 7 | | Ro | ber | t A. | Pun | nphrey | Fune | ral | Home | / mery 50-2805 |
| | Larbaia | - XD1. | 10 Julies | | rence | Av | enu | ie, F | locki | ville, | Mary | land | 2085 | 50-2805 |
| | 23. PART I. Enter the di shock, or he | states, or esrt fellure. | Complications the | t caused the | line. | not enter t | the mo | oda of dy | ying, aud | ch aa cardi | ac or reap | iratory an | reat, | Approximata interval Batween |
| | IMMEDIATE CAUSE (Fin | ei | | 10 | and - | 1. | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | → | 8 | (OR AS A CO | JW312 | hip | no | un | nu | C | | | | 36 lus |
| | | | DUE TO | (OR AS A CO | NSEOUENCE (| OF): | | | | | | | | |
| NO | Sequentially list conditi | ons, | b | (OR AS A CO | NECOLICA CO | | | | | | | | | |
| ATI | If any, leading to immed cause. Enter UNDERLY | | 502 10 | (On AS A CO | NSEGUENCE C | r: | | | | | | | | |
| RTIFICATION | CAUSE (Disease or Injusthat initiated events | | cDUE TO | (OR AS A CO | NSEOUENCE C | OF): | | | | | | | | |
| FE | resulting in death) LAS | | | | | | | | | | | | | |
| CEI | | | 0. | | | | | | | | | | | 1 |
| CAL | PART II. Other significa | nt condition | ns contributing to | death but n | not reaulting | in the unc | derlyln | ig ceuse | given in | Part I. | 24a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDIC | - | LAC | lydra | non | | | | | | _ | 1 TYES 2 | 2000 | | COMPLETION OF CAUSE OF DEATH? |
| Æ | | | 9 | | | | | | | | | | | 1 TYES 2 NO |
| ÿ | | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | QTHER | | LACE OF | DEATH (C | heck only one |) | | | |
| YSI | 1 TYES 2 NO | | 1 - Inpetient 2 | ER/Outpatier | nt 3 🗆 DOA | | | ne 5 🗆 F | lesidence | 6 🗆 Other | (Specify) | | | |
| F | 27. MANNER OF DEATH | Deadles | 28a. DATE OF (Month, D | | 28b. Till | ME OF JURY | | JURY AT DRK? | | 28d. DESC | RIBE HOW I | NJURY OC | CURED | |
| В | | Pending nvestigation | | | | M | | YES 2 | □ NO | | | | | |
| ED | | Could not be | 28e. PLACE C building, | otc. (Specify) | At home, farm, | street, tecto | ry, offic | ce | | | TION (Street Town, State) | | or Rural R | loute Number, |
| ETE | 4 Horniciae | seconnine d | | | | | | | | | | | | |
| P | | IFYING PHYS | ICIAN: To the best of | my knowledge | e, death occur | red at the tir | ne, date | end plac | a, and du | a to the caus | e(s) and ma | nner ee stat | led. | |
| COMPL | one) 2 MEDI | CAL EXAMINE | ER: On the basis of a | xamination en | d/or Investigati | on, In my op | dnion, d | death occu | ured at the | e time, date a | and place, er | nd due to th | ne cause(e) |) end menner es stated. |
| ш | 296. SIGNATURE AND TITLE | OF CERTIFIE | R 01 | | / | MI |) | 29c. LIC | CENSE NU | IMBER | | 29d. DAT | E SIGNEO | (Month, Day, Year) |
| m | Rek | · · | X pll | LLM | | 11 | | D | 0 8 | 198 | 1 | DA. | ug. | 18 1985 |
| 10 | 30. NAME AND ADDRESS OF | PERSON W | O COMPLETEO CAU | SE OF DEATH | (ITEM 27) (Typ | e, Print) | 7, | 1 | C | 000 | al | 1. | 11.1 | Les Oas A |
| | 31. DATE FILED (Month, Day, | Whari | 32 DECIOTOR | DIS SIGNATURE | DE | J - | 20 | | 30 | | Ast. | u | | There is |
| | AUG 21 | | Jalia Da | AR'S SIGNATU | 21-11 | | | | | | | | | |
| 1 | 11000 | כנכו | france wa | ander a | MANA | | | | | | | | | |



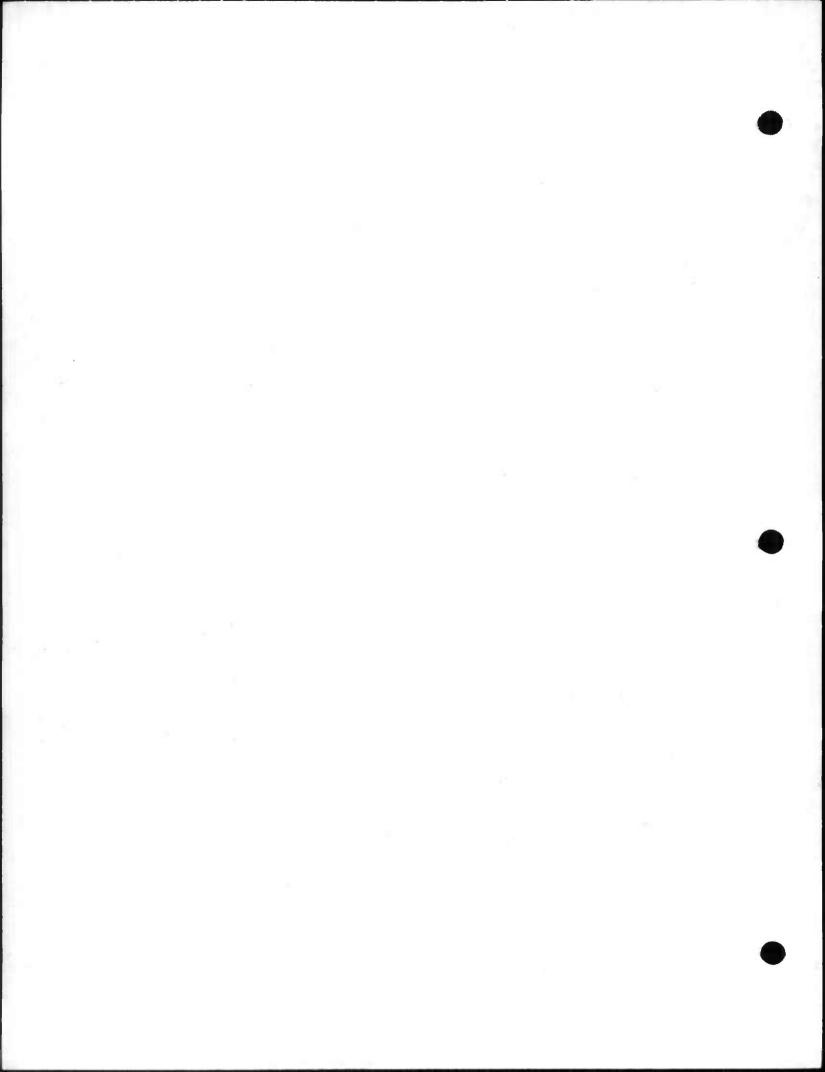
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the same length of the control of the same requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | FOR STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF H | | MENTA | L HYGIENI | E | | | | |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------|--------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------|-------------------|-------------------------------------|----------------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) CHARLOTTE | | CHARAI | PP | | 2. DATE MONT AUG | OF DEATH | . 1995 | TEAR 3. | TIME OF OEATN 2:47 PM M | | |
| | 4. SOCIAL SECURITY NUMBER 170-34-1697 | 1 🗆 M 2 💢 F | n yrs. last birthday) 89 yrs. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Mont) APR | of Birth | 1.0 | BIRTHPLA | ACE (State or Foreign NNSYLVANIA | | |
| TOR | 90. FACILITY NAME (If not institution, give s WASHINGTON ADV RESIDENCE OF DECEMENT | | AL | TAKOMA | PARK | EATN | | 9c. COUNTY MON | Y OF DEAT | | | |
| DIRECTOR | MARYLAND MO | NTGOMERY | | Y, TOWN OR LOCAT | TION | | | 18 | d. INSIDE CITY LIMITS? XY YES 2 NO | | | |
| FUNERAL | | ILL ROAD #804 | | | 20814 | | | | TATES | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 X NO | If yes, sp | CENDENT OF NISPAI ecity Cuben, Mexica 2 NO Specif | en, Puerto I | i? (Specify Yes Rican, etc.) | or No — 14 | Specify: | American Indian, Inita, etc. WHITE | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2 | JCATION le completed) Coffege (1-4 or 5+) | (Give kind of v life. Do NOT us | USUAL OCCUPATION Work done during mose retired.) | ON st of working | 16b | KINO OF BUS | | | | | |
| | 17. FATNER'S NAME (First, Middle, Last) ISAAC SHOF | F | 1101111 | Tricking | 18. MOTHER'S NA | | | | | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) DORISGAYLE GLA | DSTONE | | | and Number or Rural | | | | | AND 20814 | | |
| | 20a. METNOD OF DISPOSITION 1 Disposition 1 Deuriel 2 Cremetion 3 X Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of State Property) 20b. PLACE AND DATE OF DISPOSITION (Name of State Property) 20b. PLACE AND DATE OF DISPOSITION (Name of State Property) 20b. PLACE AND DATE OF DISPOSITION (Name of State Property) 20b. PLACE AND DATE OF DISPOSITION (Name of State Property) 20b. PLACE AND DATE OF DISPOSITION (Name of State Property) 21b. PLACE AND DATE OF DISPOSITION (Name of State Property) 21c. SIGNATURE OF FUNDS AL SERVICE LICENSEE 22c. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | |
| | · Hotel | 3 A Tron | ine | DANZAN 1170 H | NSKY-GOLI ROCKVILLI | DBERG E PIK | E - RO | CKVIL | LE. N | LS, INC. MD. 20852 | | |
| | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart tellure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) STROKE OUE TO (OR AS A CONSEQUENCE OF): Approximate interval Betwee Onset and Death Approximate | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 뒿 | | ROTIC HEART DI | | in the underlying | g ceuse given in | Part I. | 24a. WAS AN A PERFORM | MED? | CO | TRE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? | | |
| PHYSICIAN: MEDIC | HYPERTENSION DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAUSE OF | F DEATH YE | | UNCERTAIN | N D | | | 1[| YES 2 NO | | |
| YSIC | EXAMINER? | HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpe | itlent 3 🗆 DOA | OTHER: | e 5 🗆 Residence | 8 🗆 Othe | r (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | M 1 1 | YES 2 NO | 28d. OES | CRIBE NOW IN | JURY OCCUR | EO | | | |
| - 16 | 3 Suicide 8 Could not be determined | 28s. PLACE OF INJURY - building, atc. (Specif | | | | 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINE | ECIAN: To the best of my knowle ER: On the besie of exemination | | | | | | | | d menner se stated. | | |
| 0 86 | 29b. SIGNATURE AND TITLE OF CERTIFIES | - MD | | | 29c, LICENSE NUN | OS | 9 | PUG | IGNED (MO | 1, 199) | | |
| | | outo me | 1 11/2 | ent) | herep, | SS | and - | 2019 | 704 | | | |
| | 31. DATE FILE AUG 22 1995 | galla d'antique | Middell | | / | / | | | | | | |



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

ages 1, 2, 3 should

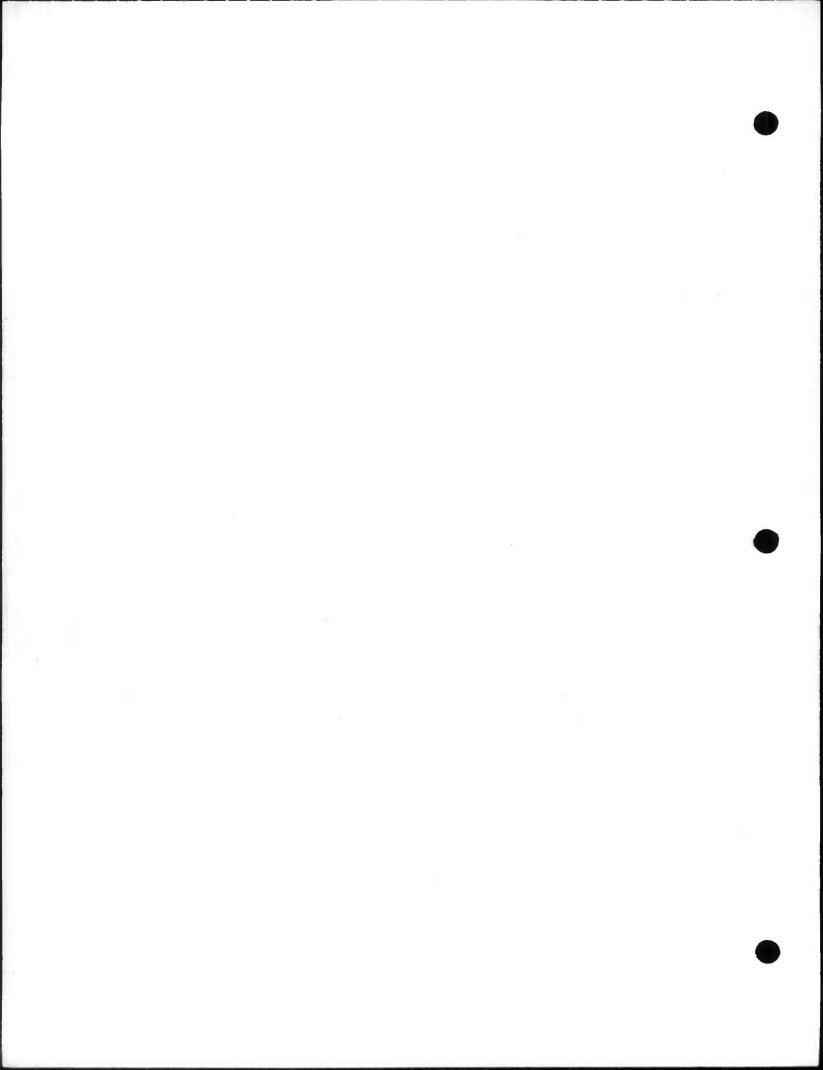
| | | | | | | | | | | 95 | 2 | 7031 |
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| | FOR 1 - STATE | STATE OF N | MARYLAND / | DEPAR | TMEN | T OF H | IEALTH | AND | MENTAL HYG | IENE | | |
| | REGISTRAR | | | ERTIF | | | | | REG | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEAT | H DAY | YEAR | 3. TIME OF DEATH |
| | Eleanor Cece | | une | | | | | | August | | | 3.35 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. la: | st birthday) | IF UNDE | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRT (Month, Day, Ye | 1 | 8. BIRTHI Country | PLACE (State or Foreign |
| | 060-12-5459 | 1 🗆 M 2 🖳 F | 87 | YRS. | MONTHS | DAYS | HOURS | MIN. | Feb. 7, | | | York |
| | 9a. FACILITY NAME (If not institution, give str | reet and number) | | | 9b. CIT | Y, TOWN | OR LOCATH | ON OF DE | | EATH | | |
| O.B. | Raphael House | | | | R | ockv | ille | | | ery | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | | | | | | | | 1 110 | | |
| E | | | | 10c. CIT | Y, TOWN | OR LOCAT | TION | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Monte | omery | | | R | <u>ockv</u> | | | | | | 1 YES 2 NO |
| RAI | | | | | | 101 | . ZIP CODI | | | 10g. CI | TIZEN OF W | HAT COUNTRY? |
| N N | | | | | | | | | | | | |
| J. | | | | | | | | | | American Indian, White, etc. | | |
| B | | | | | | | | | | у: | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) (Give kind of work done during most of working) | | | | | | | | | | White | |
| E | | | | | | | | | | | | |
| 12 | Elementary/Secondary (0-12) | College (1-4 or 5 d | •) | | , | | A • | _ 4 | | | | |
| 2 | 17. FATHER'S NAME (First, Middle, Lest) | 4 | Au | minis | LIa | rive | _ | - | ME (First, Middle, M. | rance | | |
| | Thomas Lynch | | | | | | | | in a series year to | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 10 | h MAILING | ADDOES | C /Charle | | | Theresa | | | |
| 임 | Honore C. Tiffey | | | | | | | | | | | F / |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | | | | | POL | omac, Ma | ryland | 208 | 54 |
| | 1 N Buriel 2 Cremation 3 Remo | val from State | cemetery, cre | matory or o | ther place |) C | ime or | 0 | /10/OF | LOCATION - | - City or low | g,Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | INSEE / | IGALE | OI UE | ave. | NAME A | ILE L'EL | y O | 179/93/9 | liver | Sprin | g, Maryland |
| | · 7///. // (| 1/1 | 11.11 | | | | | | llins Fu | neral | Home, | Inc. |
| | Maux . | 1/ill | un | | 5 | 00 U1 | niver | sit | Blvd., | V. Sil | .Spr. | ,MD 20901 |
| | 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory screet, Applications for best follows. A the college of the colle | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | , , , , , , , , , , , , , , , , , , , , | | 0 | | | | | | | | Interval Between Onset and Death |
| 1 1 | disesse or condition resulting in death) | Colon C | ancer | | | | | | | | | 6 mos. |
| il | | DUE TO | (OR AS A CONSE | OUENCE OF | F): | | | | | | | |
| 2 | Sequentially list conditions, | Gastric | | | | | | | | | | 6 mos. |
| ERTIFICATION | If sny, leading to immediate | | (OR AS A CONSE | | | | | | | | | |
| 일 | CAUSE (Disease or Injury | Anemia | due to | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | DOE 10 | (OH AS A CONSE | DUENCE OF | -): | | | | | | | |
| 8 | d | | | | | | | | | | | |
| | PART II. Other significent conditions | contributing to | dasth but not r | resulting i | n the u | ndariyin | cause g | Iven in | | B AN AUTOPSY | | WERE AUTOPSY FINDINGS |
| 2 | Hypertension, Ve | ntricula | r Arrthi | mia, | Artl | nriti | is, | | | S 2 (T) NO | | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | Chronic Stasis E | | | | | | | | _ ''' | Z | - 1 | OF DEATH? 1 YES 2 NO |
| - | DID TOBACCO USE CONTR | IBUTE TO CA | USE OF DEA | TH YE | SΠ | NO E | LUNC | FRTAIN | <u>-</u> | | | T TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | E OF DEAT | | | 2 0110 | LIX IZAII | 101 | | | |
| Sic | EXAMINER? 1 YES 2X NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | | s F TVba | aldanaa | 6 Other (Specify | | | |
| Ŧ | 27. MANNER OF DEATH | 28a. DATE OF | INJURY | 26b. TIM | E OF | 28c, INJ | - | SIDEIIC | 28d. DESCRIBE H | | CURED | |
| | 1 Nstural 5 Pending | (Month, D | ay, Year) | IND | URY | | AK? (ES 2 | NO | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE O | F INJURY — At ho | me, farm, s | street, fec | tory, office | | | 28f. LOCATION (S | reet and Numbe | r or Runal Ro | oute Number |
| TED | 4 Homicide determined | building, | etc. (Specify) | | | | | i | City or Town, | itate) | | |
| ۳ ا | 29a. CERTIFIER (Check only 1 2 CERTIFYING PHYSIC | IAN: To the heat of | my knowledge 4- | ath occur | ed ad the | None der- | and elec | and the | An Abra and a 1.1 | | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINER | | | | | | | | | | | and manner as stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | _, | | | | | | |
| H | AL RED P | 1/2 | | | 13 | | 29c. LICE | | | - N | | 'Month, Day, Year) |
| 2 | D 27301 August 17,1995 | | | | | | | | | | | 17,1995 |

r, M.D. 615 W. Montgomery Avenue

DOUGHES CONTROL PRINTS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

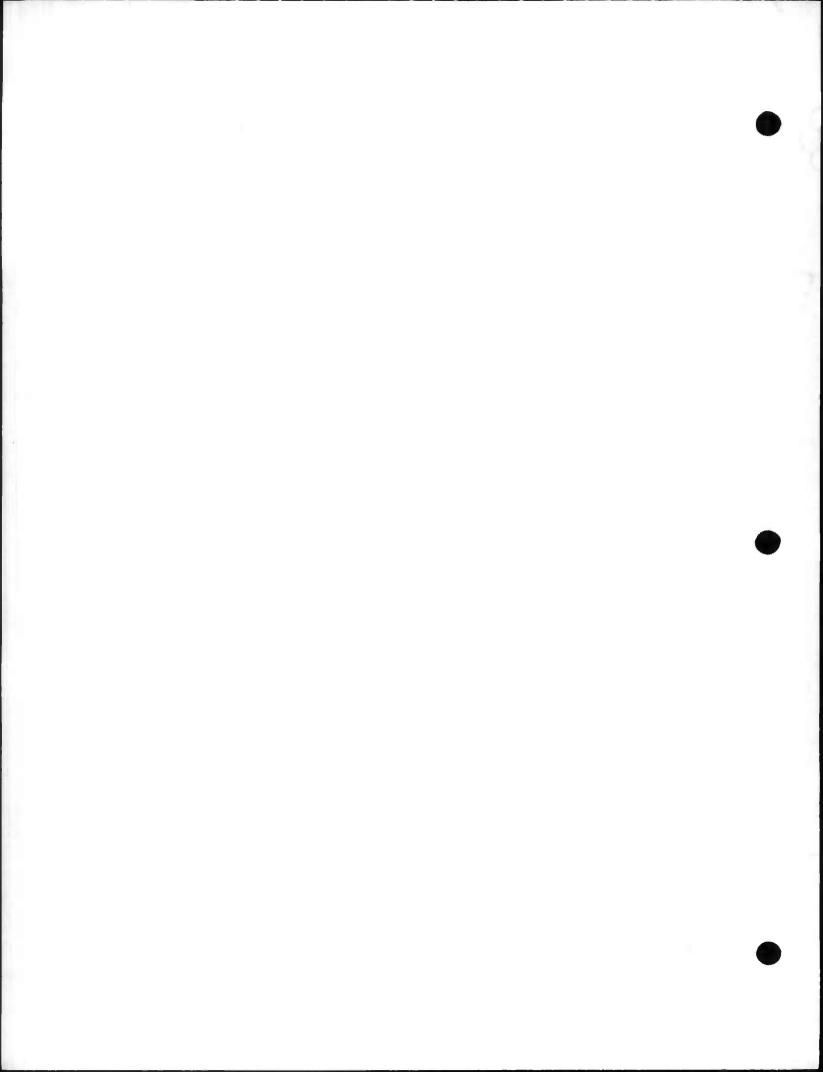
Douglas R. Shumaker,
31. DATE FILED (Month, Day, Year)
AUG 21 1995

Rockville,MD 20850



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| R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital | RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be der | Aatl |
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| A | EC | 2 |
| 8 | œ | 100 |

| | | | CERTIF | TORTE | I DEATH | REG. N | U | |
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| | 1. DECEDENT'S NAME (First, Middle, Las | | 001 | | | 2. DATE OF DEATH MONTH | DAY YE | 3. TIME OF CEATN |
| | 1 homas M | | ark | | | August | 18 199 | |
| | 100000000000000000000000000000000000000 | 1 M 2 F | (In yrs. lest birthday) YRS. | MONTHS DAY | | 7. DATE OF BIRTN (Month, Day, Year) | 8. 8 | BIRTHPLACE (State or Forei Country) |
| | 578-07-0987 99. FACILITY NAME (If not institution, give | 177 | 94 THS. | Sh CITY TOW | N OR LOCATION OF O | July 11, | 1901 V | irginia |
| H | Holy Cross Hosp | | | | | SAIN | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | er Spring | | I Mon | tgomery |
| 벌 | 10e. STATE 10b. COU | | 10c. CIT | TY, TOWN OR LO | CATION | | | 10d. INSIDE CITY |
| FUNERAL D | Maryland Mo | ntgomery | | Silver | Spring 101. ZIP CODE | | | 1 TES 2 N |
| | 11315 Norris Dri | VA. | | | 2090 | 12 | | OF WHAT COUNTRY? |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | N U.S. ARMED | 13. WAS (| | NIC ORIGIN? (Specify) | U.S. | A . RACE — American Indian. |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes, | specify Cuban, Maxic | en, Puerto Ricen, etc.) | | Black, White, etc. Specify: |
| 0 | 3 Widowed 4 Divorced | | | | | | | hite |
| п | 15. OECEDENT'S E (Specify only highest gri | OUCATION ade completed) | 18a. DECEDENT'S (Give kind of | work done during | TION most of working | 16b. KIND OF B | USINESS/INDUST | RY |
| 4 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Me. Do NOT u | | | | | |
| COMPLETED | 12 17. FATHER'S NAME (First, Middle, Last) | - 1 | Shove1 | Operato | | Const | ruction | |
| | Charles F. Clark | | | | 2-1-1 | Jo Mann | n Sumame) | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Stre | | Route Number, City or R | own, State, Zip Cod | (a) |
| 2 | Ida M. Clark | | 11315 | Norris | Drive S | ilver Spr | ing Mary | yland 2090 |
| | 20a. METHOO OF DISPOSITION 1 Strategy Burlal 2 Cremetion 3 Re | amount from State | . PLACE AND DATE | OFDISPOSITION | | | OCATION — City | |
| | 4 🗍 Donation 5 🗆 Other (Specify) | F | ort Linc | oln Cem | | /21/95 Br | entwood | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICEMEE | 18 | Eranc | AND ADDRESS OF FA | lins Fune | | |
| | "Cratt. | min | 4 | | | | | .,MD 20901 |
| 7 | 23. PART I. Enter the diseases, to | complications that ceuse List only one cause on a | d the death. Do | not enter the | mode of dying, suc | th sa cardisc or res | piratory arrest, | Approximate |
| 7 | IMMEDIATE CAUSE (Final | | | | | | | Onset and D |
| | | 100 160 4 | MA ANI I | /\ | | | | 404 |
| - 1 | disease or condition resulting in death) | · PNEU | | | | | | 1 1,00 1 |
| | | *- | A CONSEQUENCE O | | | | | |
| | resulting in death) Sequentially list conditions, | DUE TO (OR AS A | | F): | | | | |
| CALION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | A CONSEQUENCE O | F): | | | | |
| IFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | bDUE TO (OR AS / | A CONSEQUENCE O | F): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | bDUE TO (OR AS / | A CONSEQUENCE O | F): | | | | |
| 5 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d. ona contributing to death b | A CONSEQUENCE O | F): F): In the underly | ing ceuse given in | Part I. 24s. WAS A | UN AUTOPSY | 24b. WERE AUTOPSY FIND |
| 5 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b DUE TO (OR AS A DUE TO (OR AS A d | A CONSEQUENCE O | F): F): In the underly | ing couse given in | SCAPIL PERF | DRMED? | AMAILABLE PRIOR TO COMPLETION OF CAU |
| 5 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions and the conditions are sufficient conditions. | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE O | F): F): In the underly | JLAn Di | Part I. 24s. WAS A PERFIT | DRMED? | AMILABLE PRIOR TO |
| MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition of the cause of | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF A CONSEQUENCE OF DEATH YE | F): F): In the underly C J ASU | UNCERTAI | SCAP PERFO | DRMED? | AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions and the conditions are sufficient conditions. | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE O | F): F): In the underly C J ASU ES NO TN (Check only or | UNCERTAI | SCAP PERFO | DRMED? | AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? |
| MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF DEATH YE | In the underly In the underly In the underly In the underly OTH (Check only or OTHER: A □ Nursing H | UNCERTAIL One 5 Residence | PERFO | PRMED? | AMPLABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |
| PHTSICIAN: MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF DEATH YES PLACE OF DEATH STORY OF | F): F): In the underly C J A U ES NO TN (Check only or OTHER: 4 Nursing H E OF 28c. | UNCERTAIL UNCERTAIL DO OME 5 Gesidence NJURY AT WORK? | PERFO | PRMED? | AMPLABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |
| BI THISICIAN: MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF A CONSEQUENCE OF DEATH YES 26. PLACE OF DEATH SHOW IN. | F): F): In the underly C J A U ES NO TN (Check only or OTHER: 4 Nursing H E OF 28c. JURY M 1 | UNCERTAIL UNCERTAIL Del Ome 5 Residence NJURY AT WORK? YES 2 NO | PERFORMANCE TO THE PERFORMANCE T | PANED? 2 NO 3 NO 3 NO 3 NO 4 NO | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |
| בי ב | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF DEATH YES 28b. TIM. | F): F): In the underly C J A U ES NO TN (Check only or OTHER: 4 Nursing H E OF 28c. JURY M 1 | UNCERTAIL UNCERTAIL Del Ome 5 Residence NJURY AT WORK? YES 2 NO | PERFO | PANED? 2 NO INJURY OCCURE It and Number or Ri | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |
| ELED BY PHYSICIAN: MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF DEATH YES 28b. TIME INC. | F): F): In the underly C J AGU TN (Check only or OTHER: 4 Nursing H IE OF J 1 street, factory, of | UNCERTAIL | PERFORMANCE TO THE STATE OF THE | TINJURY OCCURE t and Number or Re | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF DEATH YE 26. PLACE OF DEA 28b. TIM 17. — At home, term, ordy) | F): F): In the underly C J AGU TN (Check only or OTHER: 4 Nursing H IE OF JURY M 1 street, factory, of | UNCERTAIL UNCERTAIL UNCERTAIL UNCERTAIL UNCERTAIL OFFICE OFFICE UNCERTAIL OFFICE UNCERTAIL OFFICE UNCERTAIL OFFICE UNCERTAIL OFFICE UNCERTAIL OFFICE UNCERTAIL UNCERT | PERFORMANCE TO THE STATE OF THE | TINJURY OCCURE t and Number or Rie) | AMPLABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |
| COMPLETED BY PRINCIAN: MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF DEATH YE 26. PLACE OF DEA 28b. TIM 17. — At home, term, ordy) | F): F): In the underly C J AGU TN (Check only or OTHER: 4 Nursing H IE OF JURY M 1 street, factory, of | UNCERTAIN UNCERT | B Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Street City or Yown, State to the cause(a) and m time, data and place, and the cause (b) and m time, data and place, and the cause (c) and m time, data and place, and the cause (c) and m time, data and place, and the cause (c) an | TINJURY OCCURE t and Number or Re e) | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO D D Unal Route Number, |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF A CONS | F): F): F): F): F): F): F): F): | UNCERTAIL DO UN | 8 Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Stree City or Town, Stel | INJURY OCCURE t and Number or Re enter as stated, and due to the cau 29d. DATE SIG | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO D D Ural Route Number, SNED (Month, Day, Year) |
| O BE COMPLETED BY PHYSICIAN: MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF A CONS | F): F): F): F): F): F): F): F): | UNCERTAIL DO UN | 8 Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Stree City or Town, Stel | INJURY OCCURE t and Number or Re enter as stated, and due to the cau 29d. DATE SIG | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO D D Ural Route Number, SNED (Month, Day, Year) |
| O BE COMPLETED BY PHYSICIAN: MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF A CONS | F): F): F): F): F): F): F): F): | UNCERTAIL DO UN | 8 Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Stree City or Town, Stell to the cause(a) and m time, data and place, of | INJURY OCCURE t and Number or Re enter as stated, and due to the cau 29d. DATE SIG | AMRILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO D D Ural Route Number, SNED (Month, Day, Year) |
| TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the condition | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF A CONSEQUENCE OF A CONSEQUENCE OF DEATH YES 28. PLACE OF DEATH IN. 28. PLACE OF DEATH IN. 28. TIME IN. 29. TIME IN. 20. TIME IN. 21. T | F): F): F): F): F): F): F): F): | UNCERTAIL DO UN | 8 Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Stree City or Town, Stell to the cause(a) and m time, data and place, of | INJURY OCCURE t and Number or Re enter as stated, and due to the cau 29d. DATE SIG | AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO D D Ural Route Number, SNED (Month, Day, Year) |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

| 4 | |
|----------|--|
| | |
| 68760 | |
| BOX | |
| P.O. | |
| RECORDS, | |
| OF VITAL | |
| DIVISION | |
| | |

1 - FOR STATE REGISTRAR

| | TIEGIOTTAN | | | | IOAIL | . 01 | DEAL | | н | EG. NO. | | | |
|---------------|----------------------------------------------------------------|----------------------------|--------------------------------|---------------|----------------------------------|------------|--------------|-------------------------|-----------------------------|----------------------------|----------------|-------------|-----------------------------------|
| | 1. DECEDENT'S NAME (First, Middle Last) MARGUERITE | (| C . | | Ci | T. | TEI | | 2. DATE OF E | | 21 19 | | 6.21 AM |
| | 4. SOCIAL SECURITY NUMBER 5. S | EX 8 | . AGE (In yrs. In: | t birthday) | IF UNDER | t YEAR | IF UNDER | 24 HRS. | 7. DATE OF B | | - | . BIRTHPL | LACE (State or Foreign |
| | 578-52-7055 | M 2 🖵 F | 87 | YRS. | MONTHS | DAYS | HOURS . | MIN. | (Month, Day | | , | Country) | |
| | Se. FACILITY NAME (If not institution, give street a | nd number) | 07 | | 9h CITY | TOWN C | OR LOCATH | ON OF DEA | Feb.12 | 2,190 | 9c. COUNT | | chusetts |
| œ | | | | | | | | DIT OF DEA | | | Sc. COUNT | T OF DEA | |
| 임 | Suburban Hospital | | | | Ве | thes | sda | | | | Mo | ntgo | mery |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN O | R LOCAT | TION | _ | | | | L | A MODE OTH |
| Ē | NY / A | | | | | | | | | | | | Od. INSIDE CITY LIMITS? |
| | N/A 10e. STREET AND NUMBER | N/A | | Was | hing | | | | _ | | | 1 | YES 2 NO |
| FUNERAL | | | | | | 101 | ZIP CODE | | | | 10g. CITIZE | IN OF WHA | AT COUNTRY? |
| ÿ | 3274 Aberfoyle Plac | e, N.W. | | | | | 200 | 15 | | | | U.S. | Α. |
| چُ ا | 11. MARITAL STATUS 12. 1 | MAS DECEDENT I | EVER IN II S. AD | MED | 13. V | WAS DEC | ENDENT O | F HISPANIC | ORIGIN? (Sp | pecify Yes | | | - American Indian, White, etc. |
| | | F YES, GIVE WAF | OR DATES | NO. | | | | n, Mexican, Specify: | Puerto Rican | , stc.) | | Specify: | |
| В | 3 Widowed 4 Divorced | | | | | | | .,,. | | | | | ite |
| 2 | 15. DECEDENT'S EDUCATION (Specify only highest grade complete) | | 16a. DE | CEDENT'S | USUAL OC | CUPATIO | ON | | 16b. KIN | D OF BUS | INESS/INDUS | | |
| <u> </u> | | lege (1-4 or 5+) | life | Do NOT us | vork done d se retired.) | unng mo | at of workin | g | | | | | |
| ᆲ | | 3 | N | ırse | | | | | Но | spit. | al - 1 | Medi | cal |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | | IS. MOTH | ER'S NAMI | E (First, Middle | - | | | |
| <u></u> | Stephen Collins | | | | | | | arol: | | | , | | |
| 00 | 19a, INFORMANT'S NAME (Type/Print) | | 100 | | ADARESO. | (D) | | | | Bran | | | |
| 임 | Ann C. Rowan | | | | | | | | ute Number, C | | | | |
| | | | | | | | | et (| | | | | d 20815 |
| | 20e. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Removal fr | rom State | 20b. PLACE in cemetery, cre | | therele sed | | | | | | CATION — CH | * | |
| | 4 Donation 5 Other (Specify) | Híll | Ceme | eter | У | 8/23 | 3/95 | Suit | land, | Mar | yland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSE | | 22. N | IAME AN | D ADDRES | S OF FACIL | ITY | | | | | | |
| | I Store 1) 7 | - 1 | / | | Fr | ancı | LS J. | COTI | ins F | uner | al Ho | me, | Inc. |
| - 1 | 23. PART I. Enter the diseases, or complete | MA | | | 1500 | U Ur | liver | sity | Blvd. | ,W. | Sil.S | pr., | MD 20901 |
| | ahock, or heart fallure. List o | nly one ceuse | on each line | ann. Do n | iot enier | ine mo | de or dyl | ng, such : | ss cardiac | or respir | atory arrea | it, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final | 0. | | | | | | | | | | | Onset and Death |
| | disesse or condition resulting in death) s | KENF | 2 F | AIL | _UK | E | | | | | | | 2 weds |
| | | DUE TO (O | R AS A CONSE | SEQUENCE OF): | | | | | | | 2 webs | | |
| z | C b. | MYOC | MRL | 1/22 | N INFARCTOS LEROTIC HEART DIS | | | | | | | | 2 wals |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (O | R AS A CONSE | DUENCE OF | F): | | | 1 - | | | | | |
| 5 | CAUSE (Disesse or Injury | 4RTE | RIOS | SCL | 2Ro | MI | - 1 | 120 | RT | D | 15 | | 15 Years |
| | that initiated events | OUE TO (O | R AS A CONSEC | DUENCE OF | ን: | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | | | |
| ö | | | | | | | | | | | | | † |
| 4 | PART II. Other significant conditions con | iributing to de | eth but not r | esulting i | n the unc | deriying | cause g | iven in Pa | irt i. 24a. | WAS AN A | | | ERE AUTOPSY FINDINGS |
| DICA | HYPOTENSION | | | | | | | | _ 1 | YES 2 | | CC | OMPLETION OF CAUSE |
| <u>u</u> . | | | | | | | | | | | | | YES 2 NO |
| 2 | DID TOBACCO USE CONTRIBU | TE TO CAU | SE OF DEA | TH YE | SIL | ЮГ | LINC | ERTAIN | | | | 1 | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | | | | H (Check o | | , 0110 | | | | | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO 1 | SPITAL: Inpatient 2 - E | B/Outpetlant 2 | □ noa | OTHER | | | | | | | | |
| ΞΙ | | 26e. DATE OF IN | | 28b, TiMi | | 28c. INJI | | | Other (Spe | | ILIBA OCCIII | DEO | |
| | t Natural 5 Pending | (Month, Day, | Year) | INJ | URY | WO | RK7 | | od. OLGONIE | E HOW III | JOHN OCCU | NEO | |
| à l | 2 Accident Investigation | 26e. PLACE OF I | MINDY As he | 4 | | | | | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | building, ato | . (Specify) | me, rerm, a | rreet, tecto | гу, опис | • | l ² | 6t. LOCATION City or Tov | N (Street er vn, State) | nd Number or | Rural Rout | te Number, |
| | | | | | | | | | | | | | |
| MPLE | 29e. CERTIFIER CERTIFYING PHYSICIAN: | To the beet of my | y knowledge, de | eth occurre | d at the tin | ne, date | and place, | end due to | the cause(e) | end mann | ner ee stated. | | |
| S S S | one) 2 MEDICAL EXAMINER: On | the basis of exam | nination end/or i | nvestigatio | n, In my op | Inlon, de | eath occur | ed at the tin | ne, date and | place, and | due to the c | cause(e) ei | nd manner ee stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 1 | | | | | 29c LICE | NSE NUMBI | FR | | 204 DATE 9 | NONED (M | fonth, Day, Year) |
| 4 | Daniel Kan | . 1/ | 111 | | | | 7 | 47 | 66 | | | | -95 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COM | PLETEO CALLES | OF DEATH (ITE | 127/3 | Dolott . | | ~ | . / | 7 | | 8. | - 21 | -73 |
| | DR DANIEL ROSE | | MI | n arj (nype, | 1 | 500 | SINO | NNE | CTIC | TUT | 2089 | 60 | 6 |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S | SIGNATURE | 4 4 | | | | | | | | | |
| | AUG 23 1995 | ulia Dave | dear Rand | all | | | | | | | | | |
| | | | | | | | | | | | | | |

n ·

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flowing that have 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the flowing flowing the following the feather of the signed by the attending physician and one physician and Mental Hygiene prior to burial, cremation, or immortal examiner must be neitfled at once.

| | 1 - FOR STATE REGISTRAR | TE OF MARYLAND | | MENT OF H | | MENTAL HYGIEN | | | | |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------|----------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) Gera | | nway | | | 2. DATE OF DEATH DATE OF AUGUST 19 | , 1995 | 3. TIME OF DEATH 3:00 P. M | | |
| TOR | | w 2 □ F 66 | YRS. | IF UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Pay Year) NOV • 12, 19 | 28 Ma | ryland | | |
| | 98. FACILITY NAME (If not institution, give street and #7 Lakeside Drive | | 96. CITY, TOWN OR LOCATION OF DEATH Greenbelt | | | | Prince George's | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | ATE 10b. COUNTY | | | | · | 10d. INSIDE CITY LIMITS? XX YES 2 \(\sum \) NO | | | |
| FUNERAL | #7 Lakeside Driv | | 101. ZIP CODE 20770 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| B≺ | 11. MARITAL STATUS 1 Never Married XXX Married 3 Widowed 4 Divorced | IF YES GIVE WAR OR DATES." | | | | IIC ORIGIN? (Specify Yes n, Puerto Rican, atc.) | ea or No— 14. RACE — American Indian, Black, Whita, atc. Specify: White | | | |
| COMPLETED | (Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+) | | | SUAL OCCUPATION to done during most retired.) | st of working | | 16b. KIND OF BUSINESS/INDUSTRY Prince George's Co. Sch | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) James Gabriel Conway | | | - Courses | | ME (First, Middle, Melden Mae Masc | en Surname) | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) Joan M. Conway 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 | n State 20b. PLACE cemetery, co | | | August : | 21,1995 Ale | cation - city or t xandria, V | irginia | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENSEE | wardt. | | | | gwardt Fur 111 Rd. Be | | me, P.A. e, Md.20705 | | |
| | 23. PART I. Enter the disesses, or compile shock, or haert feilure. List on IMMEDIATE CAUSE (Finel disesse or condition resulting in death) | plons that ceueed the discourage on each line. DUE TO (DR AS A CONSI | Ac | | Lluke | | ratory srrest, | Approximats intervsi Between Onset and Death | | |
| CERTIFICATION | Sequentisity list conditione, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | |
| AN: M | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| HYSICI | EXAMINER? 1 VES 2 NO 1 Ing | PITAL: patient 2 ER/Outpetient | | THER: | | 8 Other (Specify) | | | | |
| B | 1 Natural 5 Pending 2/ Accident Investigation | 1 Natural 5 Pending (Month, Day, Year) 2/ Accident Investigation | | | IJURY WORK? M 1 □ YES 2 NO | | | of and Number or Rural Route Number | | |
| COMPLETED | 4 Homicide determined building, atc. (Specify) City or Town, Stete) | | | | | | | | | |
| COMP | (Check only 1 CENTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| TO BE | 296. SIGNATURE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) AUGUST 21, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | CLARA CHAN, M 31. DATE FILED (Month, Day, Year) 32 | D. 7525 | GYEL | nway | y Cent | er Dr. G | Yeenbel | t, MD | | |
| | AUG 23 1995 | REGISTRAN'S SIGNATURE Dawelson Randa | Ц, | | 7 | | | | | |

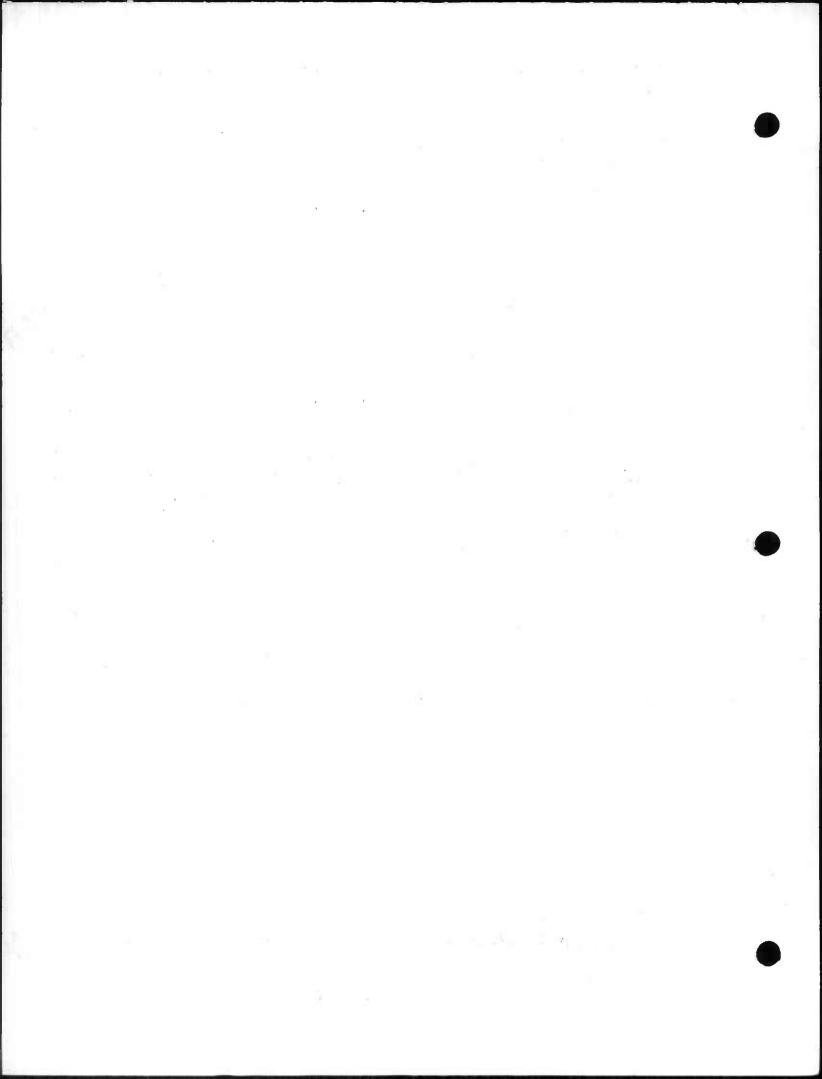
trie 2 2

| 760, BALTIMORE, MARYLAND 21215-0020 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | event, the medical examiner must be notified at once. |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate to | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH August 2 3. TIME OF DEATH 1995 Sister Bertha Cahill

| Sister Bertha Cahill August 27, 1995 7:00 A | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------|----------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------|
| 4. SOCIAL SECURITY NUMBER | 1 | 5. SEX | 6. AGE (In yrs | . last birthday) | IF UNDE | 1 | IF UNDER | | 7. DATE | OF BIRTH | | 8. BIRTHP Country | LACE (State or Foreign |
| 579-66-673 | | 1 M 2 TF | 8 | 9 YRS. | MONTHS | DAYS | HOURS | MIN. | | . 8, 1 | 1906 | Ball | yard, Ire |
| 90. FACILITY NAME (If not instit | ot institution, give street and number) | | | | 9b. CIT | , TOWN OF | LOCATIO | N OF DE | EATH | | 9c. COU | INTY OF DE | |
| Villa St. Michael | | | | | Emmitsburg, Frederick | | | | | | .ck | | |
| | | | | | | | | | | | 1 | | |
| | 10a. STATE 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION 10d, INSID | | | | | 10d, INSIDE CITY LIMITS? | | | |
| Maryland | Free | derick | | E | mmit | sburg | | | | | ₹ YES 2 NO | | |
| 10e. STREET AND NUMBER | | | | | | 10f. ZIP CODE | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| 333 S. Seton Avenue, Emmitsbur | | | | | | | | | | | | | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S 13. TORCES? 1 ☐ YES 2 | | | YES 2 | NO | NO If yee, specify Cuben, Mexican, Puerto Ricen, etc.) Black, Wh | | | | | - American Indien, White, etc. | | | |
| 3 Widowed 4 Divorce | | IF YES, GIVE W | AR OR DATES | | 1 TES 2 TO Specify: | | | | | | Specify | Specify: White | |
| 15. DECEDENT'S EDUCATION 16s. | | | | | DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY | | | | | | | WILLEC | |
| (Specify only highest grade completed) | | | (Give kind of work done during most of working life. Do NOT use relired.) Religious Community | | | | | | | 437 | | | |
| Elementery/Secondary (0-12 | College (1-4 or 5+) College + | | | Nurse | , | 700.7 | | | Daughters o | | | | |
| 17. FATHER'S NAME (First, Midd | lle Last) | College | T . | nurse | | | 10 MOTH | ED'S NA | | | | Chai | ILY |
| John Cahil | | | | | | 18. MOTNER'S NAME (First, Middle, Meiden Surname) | | | | | | | |
| 190. INFORMANT'S NAME (Type | | | | 105 MAII IMC | Ellen Kearney | | | | | | | | |
| Sister Cami | 177 | um am tr | | 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 333 S. Seton Ave., Emmitsburg, MD 21727 | | | | | | | | | |
| | | | 205 BLA | | | | | | | | | | |
| 20a. METNOD OF DISPOSITION 1A Burlal 2 Cremellon A Donation S Other (S) | | rval from State | cemetery | , crematory or o | other place) | D x o | 14 01 17 7 7 70 | 010 | 8/29 | /195 | Emm i | tshi | ira, MD |
| 4 Donation 5 Other (Specify) St. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 0056 | CEAND DATE OF DISPOSITION (Name of Companion | | | | | | | | |
| ► (1) 100; H De | | | | | | | | | | | | | |
| 23. PART I. Enter the dise | m /1 | . / Yitt | in | | | | | | | tysb | 400 | | |
| disease or condition resulting in death) a. Gangrenz of FEET Due to (gras a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST Due to (gras a consequence of): CARDIO VASCULAR DISEASE Due to (or as a consequence of): CARDIO VASCULAR DISEASE Due to (or as a consequence of): | | | | | | | | | | | | | |
| if any, leeding to immedia cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | ns, ate | DUE TO | COR AS A CON | ISEOUENCE O | P): | C (| CAR | PI | OVI | 1300 | LA | RP | 15+12 15+12 |
| If any, leeding to immedia cause. Enter UNDERLYIN/ CAUSE (Disease or Injury that initiated events resulting in deeth) LAST | | | | | | | | | | 1300 | CA | RP | 15 428 15 428 |
| if any, leeding to immedia cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | | | | | | | | | 24a. WAS AN PERFOI | AUTOPSY | 24b. \ | WERE AUTOPSY FINDINGS MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I | conditions | | | | | nderlyIng | ceuse g | iven in | Part i. | 24e. WAS AN PERFOI 1 TYES 2 | AUTOPSY | 24b. \ | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I EXAMINER? | conditions | s contributing to | deeth but n | ot resulting | In the u | 26. PLA | ceuse g | Iven In | Part i. | 24a. WAS AN PERFOI | AUTOPSY | 24b. \ | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| if any, leeding to immedia cause. Enter UNDERLYINV CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant | conditions | s contributing to | deeth but n | ot reaulting | OTHE | 26. PLA | CE OF DE | Iven In | Part i. | 24e. WAS AN PERFOI | AUTOPSY RMED? | 246. | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Notural S Pe | conditions | s contributing to | deeth but n | ot reaulting | OTHE | 26. PLA R: noing Nome 28c. INJUI | CE OF DE | EATN (Chi | Part i. | 24a. WAS AN PERFOI | AUTOPSY RMED? | 246. | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| If any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide 29e. CERTIFIER (Check only) | conditions MEDICAL Inding estigation and not be estimated. | HOSPITAL: 1 Department 2 Depart | BR/Outpatien INJURY ay, Year) FINJURY — A etc. (Specify) | ot resulting | OTHE 4 Number of Street, fac | 26. PLA R: rsing Ninyl WOR 1 Ye tory, office | CE OF DE | EATN (Chi | Part i. eck only one 6 Other 28d. DES 28l. LOC. City (| 24a. WAS AN PERFO! 1 YES 2 (Specify) CRIBE NOW ATION (Street or Town, State) | AUTOPSY MED? NUMY OC NUMPO | 26b. V | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| if any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide 6 Co 29e. CERTIFIER (Check only) | conditions MEDICAL Inding actigation uld not be elemined YING PNYSIC LL EXAMINER | HOSPITAL: 1 Papetient 2 28e. DATE OF (Month, D building, | BR/Outpatien INJURY ay, Year) FINJURY — A etc. (Specify) | ot resulting | OTHE 4 Number of Street, fac | 26. PLA R: reling Nome 26c. INJUI WOR 1 VE tory, office | CE OF DE | EATN (Che sidence (NO end due end at the | Part i. eck only one © Other 2ad. DES 26I. LOC: City of to the cau tima, date | 24a. WAS AN PERFO! 1 YES 2 (Specify) CRIBE NOW ATION (Street or Town, State) | AUTOPSY NAMED? NAMED? NAMED? NAMED? NAMED? | 26b. V. CURED or or Rural Ro | WERE AUTOPSY FINDINGS MARILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? I YES 2 NO ute Number, |
| if any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide dei 29e. CERTIFIER (Check only one) 2 MEDICA | conditions MEDICAL Inding actigation uld not be elemined YING PNYSIC LL EXAMINER | HOSPITAL: 1 Papetient 2 28e. DATE OF (Month, D building, | BR/Outpatien INJURY ay, Year) FINJURY — A etc. (Specify) | ot resulting | OTHE 4 Number of Street, fac | 26. PLA R: reling Nome 26c. INJUI WOR 1 VE tory, office | CE OF DE | EATN (Che sidence (NO end due end at the | Part i. eck only one © Other 2ad. DES 26I. LOC: City of to the cau tima, date | 24a. WAS AN PERFO! 1 YES 2 (Specify) CRIBE NOW ATION (Street or Town, State) | AUTOPSY NAMED? NAMED? NAMED? NAMED? NAMED? | 26b. V. CURED or or Rural Ro | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| if any, leeding to immedia cause. Enter UNDERLYINK CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide dei 29e. CERTIFIER (Check only one) 2 MEDICA | conditions MEDICAL Inding entigetion uid not be ermined VING PNYSIC LEXAMINEF CERTIFIER | HOSPITAL: 1 Department 2 See. DATE Of (Month, D) 28e. PLACE O building, CIAN: To the best of e: | BER/Outpatien INJURY ay, Veer etc. (Specify) my knowledge xemination end | ot resulting t 3 DOA 28b. TIM IN. t home, ferm, | OTHE 4 Nui 8E OF JURY M streel, fac | 26. PLA R: reling Nome 26c. INJUI WOR 1 VE tory, office | CE OF DE | EATN (Che sidence (NO end due end at the | Part i. eck only one © Other 2ad. DES 26I. LOC: City of to the cau tima, date | 24a. WAS AN PERFO! 1 YES 2 (Specify) CRIBE NOW ATION (Street or Town, State) | AUTOPSY NAMED? NAMED? NAMED? NAMED? NAMED? | 26b. V. CURED or or Rural Ro | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH? I YES 2 NO ute Number, |

ZED 0 1 1232



95 27036

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

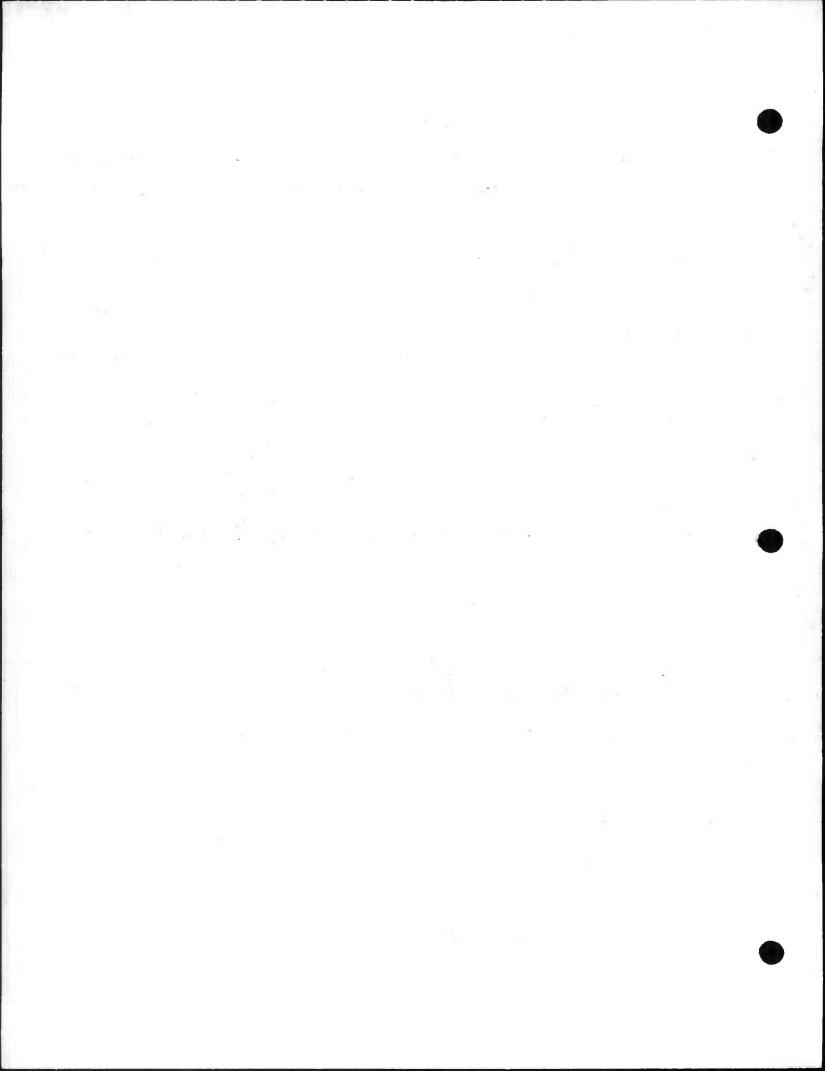
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

| | REGISTRAR | | CERTIF | ICALE (| OF DEATH | REG. NO | | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------|------------------------|---------------------------------------------------|----------------------------------------|----------------------------------------------------|--------------------------------|----------------------|--|
| DIRECTOR | 1. DECEDENT'S NAME (First, Middle, Leet) Ronald E | Dicke | erson | | 2. DATE OF DEAT MONTH August | | | 13 1995 3. TIME OF DEATH 8:15a | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | SE (In yrs. lest birthday) | IF UNDER 1 YE | | 7. DATE OF BIRTH | 1 | BIRTNPLACE | (State or Foreign | |
| | 577-72-3417 | 1 x M 2 🗆 F | 43 YRS. | MONTHS DA | YE HOURS MIN. | Mar. 28, 19 | 52 W | Vash. I | o.c. | |
| | 9a. FACILITY NAME (If not institution, give s | | | 9b. CITY, TO | WN OR LOCATION OF D | | 9c. COUNTY OF DEATH | | | |
| | WASHINGTON ADVENTIST HOSPITAL | | | | a Park | | Montgomery | | | |
| | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | , | 10c. CIT | Y, TOWN OR L | OCATION | | | 1 404 1 | NOIDE OITY | |
| DIR | D.C. | | | | on, D.C. | | | L | NSIDE CITY JMITS? | |
| FUNERAL (| 10a. STREET AND NUMBER | | | 101. ZIP CODE | | 1 № YES 2 NO | | | | |
| | 2431 Alabama Aven | ue, S.E. | | 20019 | | | | 00111111 | | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify | | | or No- 1 | 4. RACE — Am Black, White | nerican Indian. | | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | yes 2 X NO Speci | en, Puerto Ricen, etc.) | | Black, White Specify: | , atc. | |
| | | | | | | | | Blac | ck | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 18a. DECEDENT'S (Give kind of life. Do NOT u | work done durin | PATION g most of working | 16b. KIND OF BUS | SINESS/INDUS | STRY | | |
| J. | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | | | |
| MC | 12th 17. FATHER'S NAME (First, Middle, Last) | | • | Nat'1. Capitol Housing | | | | | | |
| | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| BE | Eugene Dickerson 19a. INFORMANT'S NAME (Type/Print) | | 19h MAH ING | ADDRESS (S) | | llen Willia Aoute Number, City or Tow | | | | |
| 5 | Mary Ellen Darrin | aton | | | | 1,Suitland | | | | |
| | | | | | | | | | ria . | |
| | 20a. METHOD OF DISPOSITION 1 | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral HOme, Inc. | | | | | | | | | |
| | D. P. Sm. | .0.00 | • | | | | | | | |
| - | 23. PART I Enter the diseases or o | complications that saw | and the death. Do | 4308 | Sultland | Rd., Suit | Land, | | | |
| - 1 | 23. PATT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Acquired imm undertung industry and Death | | | | | | | | | |
| 1 | resulting in death) Due to (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| - | | 1 | A CONSCOURNE O | r). | | | 6.1 | | | |
| CERTIFICATION | Sequentially llat conditions, if any, leading to immediate DUE to (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CA | CAUSE (Disease or Injury | | | | | | | | | |
| E | that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ER | resulting in death) LAST d | | | | | | | | | |
| | PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | |
| EDICAL | PERFORMED? AMAILABLE PRIOR TO | | | | | | | | | |
| | 1 U YES 2 NO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | |
| Σ | 1 UES 2 NO | | | | | | | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES UNCERTAIN UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| SIC | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpellant 2 ER/Outpetlent 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) | | | | | | | | | |
| ξ | 27. MANNER OF DEATN | 28s. DATE OF INJUR | Y 28b. TIM | E OF 28c. | INJURY AT | 28d. DESCRIBE NOW II | NJURY OCCUI | RED | | |
| ВУР | 1 Natural 5 Pending | (Month, Day, Year | M 1 | | | | | | | |
| | 3 Suicide 28e. PLACE OF INJURY — At home, farm, st | | | | office | 281. LOCATION (Street a | LOCATION (Street and Number or Rural Route Number, | | | |
| W I | 4 Nomicide detarmined building, atc. (Specify) | | | | | | | | | |
| PE | 29a. CERTIFIER (Chick poly Control poly Indicated a state of the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| COMPLET | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 201 SWALL BE AND TITLE OF CERTIFIED | | | | | | | | | |
| 8 | 29ch (CENSE NUMBER G G 29d, Date Signed (Month, Day, Joan) | | | | | | | | | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, | Print) | 1 +01 | 111 | 300 | 7-4 | | |
| | DR LEWIS | 1 | | | 1t. RdCo1 | lege Dark | MD 2 | 0740 | | |
| | 31. DATE FILED (Month, Day, 19ar) 32. REGISTRAR'S SIGNATURE AUG 24 1995 AUG 24 1995 AUG 24 1995 AUG 24 1995 | | | | | | | | | |
| | AUG 24 1995 | your develor | Narball | | | | | | | |



hospital or attending physician. ached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the death. Page 6 may be retained by the | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be deta | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at one |
| The | le h | te D | E |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIE | | |
|---------------|-------------------------------------------------------------|---------------------------------------------|---------------------------------|----------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | | Lucy DeGen | naro | | | August 1 | 4 199 | 4:00 AM M |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 0. | BIRTHPLACE (State or Foreign |
| | 045-05-3015 | | 84 YRS. | MONTHS DAYS | HOURS MIN. | | | country) ew Haven Conn. |
| | 9e. FACILITY NAME (If not institution, give s | treet and number) | | 96. CITY, TOWN C | OR LOCATION OF DE | ATH | 9c. COUNTY | |
| l e | Crofton Convalesc | ent Center | | Cro | fton | | Anne | Arundel |
| [[| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c CITY | TOWN OR LOCAT | | | | |
| DIRECTOR | Connecticut New 1 | Haven | | Haven | 1011 | | | 10d. INSIDE CITY LIMITS? |
| | 10a. STREET AND NUMBER | naven | New | | . ZIP CODE | | 10g CITIZEN | 1 TYES 2 NO |
| FUNERAL | 278 St. Johns Str | eet | | | 6511 | | | ISA |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | | | IIC ORIGIN? (Specify | | . RACE — American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 YES | | If yes, spe | ecify Cuban, Maxica 2 1 NO Specify | n, Puerto Rican, atc.) | | Black, White, etc. Specify: |
| BY C | 3 Widowed 4 Divorced | | | | - 20 | | | White |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S U | vrk done during mos | ON st of working | 16b. KIND OF E | USINESS/INDUS | TRY |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use | | | 1 | | |
| COMPL | 1 2 17. FATHER'S NAME (First, Middle, Last) | | Supervi | sor | | The second secon | othing | |
| | | | | | | ME (First, Middle, Maid | en Sumame) | |
| H | John Conte 19e. INFORMANT'S NAME (Type/Print) | | 405 4441 1910 4 | 22222 | | de Conte | | |
| 2 | John DeGennaro | | | | | Route Number, City or 1 | | de) |
| | 20s. METNOD OF DISPOSITION | 20 | b. PLACE AND DATE OF | | | fton, Md. | ZIII4 LOCATION — City | |
| | 1 Buriel 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | oval from State cer | metery, commetory or other | er place) | | | | ven Connecticut |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | TT DUTITED | 22 NAME AN | D ADDRESS OF EA | CH (TEX | | |
| | R1.40 | Evans: P | | | | ns Funera | | |
| | 23. PART I. Enter the diseases, or c | Value F | nos. | 16000 | Annapol: | is Road B | owie, M | aryland 20715 |
| | anock, or heart fellure. | List only one ceuse on e | each line. | t enter tha mod | de ot dying, suci | h aa cardlac or rea | piratory arrest | Approximata interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | Carl | 14 | 1 0 | 1 | | | Onset and Death |
| | resulting in death) | B. OUF TO (OR AS | A CONSEQUENCE OF | Arra | V . | | | |
| 7 | | [osing | A CONSEQUENCE OF: | ear E | Dereal | 2 | | 5 years |
| 흔 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | CONSPOUENCE OF | | | | | |
| S | ceuse. Enter UNDERLYING CAUSE (Disease or Injury | с | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| CERTIFICATION | Totaling in death, Exs. | d | | | | | | |
| AL C | PART II. Other algnificent condition | a contributing to deeth I | out not resulting in | the underlying | ceuse given in | Part I. 24a, WAS | IN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| | Advar | red A | 13 Lein | eis | dina | PERF | ORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | 1 🗆 YES | 2 MO | OF DEATH? |
| 2 | DID TOBACCO USE CONTI | RIBUTE TO CAUSE C | OF DEATH YES | П NO П | UNCERTAIN | J PI | | 1 TYES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH | | O. (GEICH) | | | |
| Sic | 1 VES 2 NO | HOSPITAL: | petient 3 DOA | THER: | 5 🗆 Residence | 6 Other (Specify) | | |
| РНУ | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJUI | OF 28c, INJI | URY AT | 26d. DESCRIBE HOY | INJURY OCCUR | ED |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | (11101111, 04), 1041) | in soil | | ES 2 NO | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, atc. (Spe | f — At home, farm, str cffy) | eet, fectory, office | | 281. LOCATION (Street City or Town, Ste | | Rurel Route Number, |
| | 4 Nomicide determined | | | | | ony or rown, one | 6) | |
| P | (Check only 1 CERTIFYING PHYSIC | CIAN: To the beat of my know | riedge, death occurred | at the time, data | and place, and due | to the cause(a) and m | anner as stated, | |
| COMPLETED | one) 2 MEDICAL EXAMINE | R: On the beals of examination | n and/or investigation, | In my opinion, de | eath occured at the | time, data and place, | and due to the ce | suse(a) and manner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | 2 / | 1 | | 29c. LICENSE NUM | BER | | GNED (Month, Day, Year) |
| TO B | Paul s | 5 / Chor | les W | 7) | 022 | 028 | 18 | -14-95 |
| - | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | | 100 | , / | - | | |
| | raul s | Khode | _ | 561 C | of tar | Cente | Cod + | n My |
| | 31. DATE FILED (Month, Day, Year) AUG 25 1995 | 132 REGISTERATE SIGN | Mariak | | | | 0 | |



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and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit. Page 6 may be retained by the hospital or attending physician. hours after death. the attending physician Mental Hygiene prior to prior

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

OR ATTENDING PHYSICIAN: The

FUNERAL I within 72 h HOSPITAL

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TO THE HOSPITA
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De filed within 7
IMPORTANT: I

4 | Homicide

permit, Pages 1, 2, 3 should

notified at å must medical examiner the event. traumatic 2 other t 6 shows any injury, signed by t Health and been . has b 23 r this certificate h 6 marked, After the 69 DIRECTOR:

Amended # 1 8-21-95
TMT Toubot Co.
FOR
1 - STATE REGISTRAR
STATE OF STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Gindy Deese Lauren 212 AUG. 6, 1995 1625 95 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 1 - M 2 57 DAYS HOURS YRS. MARYLAND 11 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR UNIV. OF MARYLAND HOSPITAL BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND QUEEN ANNE'S CENTREVILLE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 200 POPLAR DRIVE 21617 USA 11. MARITAL STATUS
1 Never Merried 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) -0-N/A N/A 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname DALE L. DEESE 8 CINDY CRAWFORD 19e. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 DALE L. DEESE 200 POPLAR DRIVE, CENTREVILLE, MD 21617 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Burlet 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY 8-19 CENTREVILLE, MD 4 ☐ Donation 6 ☐ Other (Specify) _ 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. MERCERON CFS \$200 S. HARRISON ST., EASTON, NHOF MD 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Bety **Onset and Death** IMMEDIATE CAUSE (Fine) disease or condition_ Faller DUE TO (OR AS A CONSEQUENCE OF): 11 days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TES 2 TIME OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 1 Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, lectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be

29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) て. 47798 August 17,1955 MD 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Blake Street Baltimore

25.

Gree

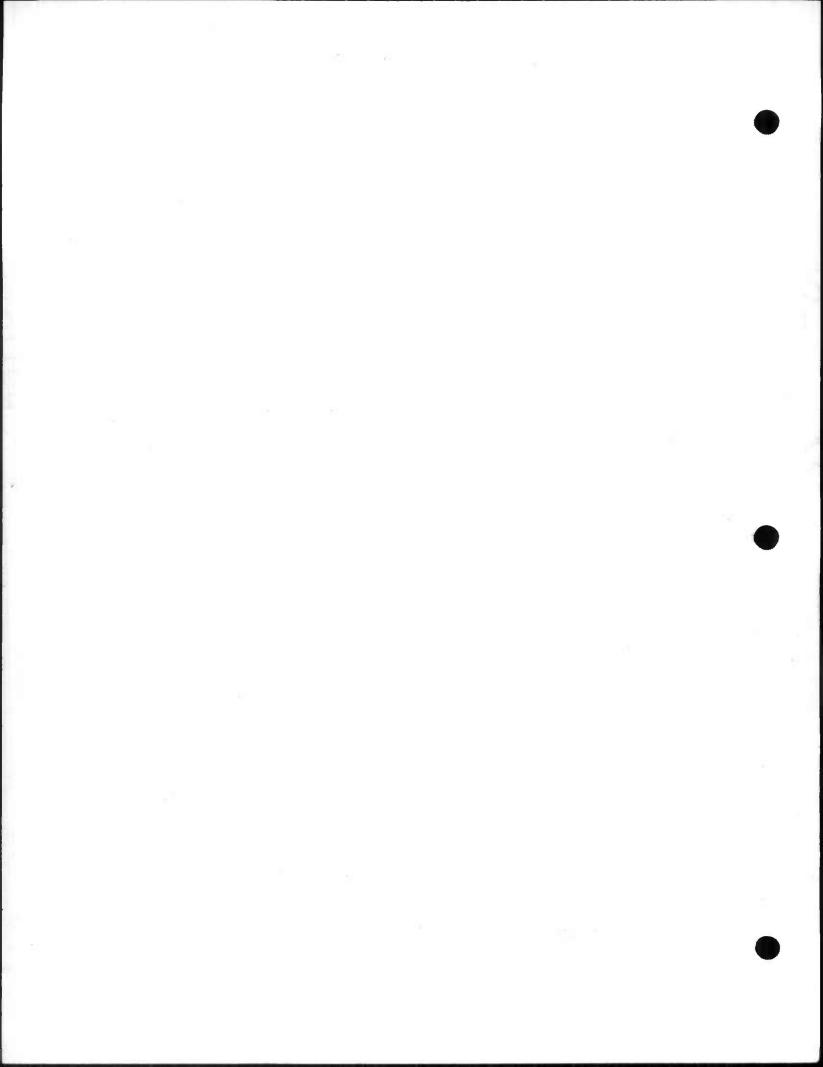
A 12. REGISTRAT'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | REGISTRAR | | CE | RUM | CATE | PF DEA | IH | | REG. NO. | | | |
|-----------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------|--------------------------------------|----------------|-------------------------------------------|--------------------------------|-----------------|------------|-----------|------------------|--------------|------------|------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE | OF DEATH | W | YEAR : | . TIME OF DEATH |
| | | Edgar | Dennis | | | | | | | st 16 | | | 3:00 A M |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. les | | IF UNDER 1 YEA | | 9 24 HRS. | | OF BIRTH | | I. BIRTHPI | LACE (State or Foreign |
| 70 | | 220- 12-0312 | 1 🔀 M 2 🗆 F | 78 | g yrs. | MONTHS DAY | S HOURS | MIN. | | 14, | 1916 | Mary | |
| houl | | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, TOW | N OR LOCATI | ON OF DE | | | 9c. COUNT | | |
| 65 | RO | Meridian - The | Pines | | | Ea | ston | | | | m-1 | bot | |
| | 5 | RESIDENCE OF DECEDENT | | | | | | | | | 191 | DOL | |
| Sades | DIRECTOR | 10a. STATE 10b. COUNTY | | | 10c. CITY, | TOWN OR LO | CATION | | | | | 1 | Od. INSIDE CITY |
| F. | | Maryland Talb | ot | | St. | Micha | els | | | | | 1 | X YES 2 NO |
| Ded. | ₹ | 10e. STREET AND NUMBER | | | | | 10f. ZIP COD | E | _ | | 10g. CITIZI | EN OF WH | AT COUNTRY? |
| physician. burial-transit permit. Pages 1, 2, 3 should | FUNERAL | 304 N. Talbot St | , P.O. Box | 411 | | | 2166 | 63 | | | USA | A | |
| physician burial-tra | E I | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENTYEVER FORCES? 1 X YE | R IN U.S. AR | MED | 13. WAS | SECENDENT (| OF HISPAN | IC ORIGIN | ? (Specify Yea | or No- 1 | 4. RACE - | - American Indien, White, stc. |
| | ВУ | 3 Widowed 4 Divorced | IF YES, OIVE WAR OR | DATES | | | ES 2 XNO | | | incert, etc.) | | | Black |
| attending se as the | | | | | | | | | - | | | | |
| use at | COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | (G/ | CEDENT'S U ve kind of wo Do NOT use | ISUAL OCCUP ork done during | Most of working | ng | 16b. | KIND OF BUS | INESS/INDU | STRY | |
| | 1 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | , | | | | | | | |
| the hospital detached fo | M | 9th 17. FATHER'S NAME (First, Middle, Last) | | U | ohols | tery | | | | Noble | | | |
| be der | | | | | | | | | | ficidle, Maiden | Surname) | | |
| | 띪 | Howard J. Dennis | | | | | | adie | | | | | |
| 5 should notified | 2 | | | - 1 | | | | | | er, City or Town | | | 21663 |
| | | Jeanette Milbour | | | | | | P.0 | | | | | naels, Md. |
| after death. Page 6 may be by the funeral director, page moval. | | 1 Surial 2 Cremation 3 Remo | rval from State | emelery, cres | matory or oth | er place) | | | OATE | | CATION — CI | ty or Town | n, State |
| Page (al direc | | 4 ☐ Donation 6 ☐ Other (Specify) | | Md. V | /etera | ans Ce | | | | 9/95 | Beula | ih, M | ſd. |
| death. Page tuneral din | 1 1 | | THE . | | | | ennie | | | neral | Servi | CAS | |
| he fe | | 1/1/2 | | | | | | | | Eastor | | | 601 |
| d in by the or removal | | 23. PART I. Enter the disesses, or c | omplications that caus | ed the de | ath. Do no | ot enter the | mode of dy | ing, such | as card | lac or respin | ratory arrei | et, | Approximate |
| | | shock, or heart fellure. L | | | | | | | | | | 4 | Interval Batween Onset and Death |
| the the | | disease or condition resulting in death) | RIGHT | - H | EMI | PM | ES15 | الرا | TH | - MOH | M51 | A | 2/15/95 |
| ompletely fills i, cremation, event, the | | Tooding in death) | DUE TO (OR AS | A CONSEC | UENCE OF | : | | | () () | 179 17 | | | 10113 |
| | z | | RIGHT DUE TO (OR AS | RR | a VI | 1500 | SUN | 2 | Ac | C 12 | BN | 1 | 2/15/95 |
| h certificate be executionally physician and confine prior to burian or other traumatic | CERTIFICATION | If any, leading to immediate | DUE TO (OR AS | | | : | | | | | | | 111111111111111111111111111111111111111 |
| recrificate be ex nding physician a Hygiene prior to or other traums | 2 | CAUSE (Disesse or injury | | | | | | | | | | | |
| certificate ding physi- hygiene pri | ᄩ | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEC | UENCE OF): | | | | | | | | |
| death certi e attending ental Hygie | 55 | a d | | | | | | | | | | | - |
| Me de | | PART II. Other significent conditions | contributing to deeth | but not re | sulting in | the underly | ing ceuse g | given in F | Part I. | 24s. WAS AN | AUTOPSY | 24b. W | ERE AUTOPSY FINDINGS |
| that the ed by the and the and in | EDICAL | | | | | | | | | PERFOR | 1 | A | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| 5 6 6 E | W | | | | | | | | _ | 1 TES 2 | NO | 0 | F DEATH? |
| of of other | Σ | DID TOBACCO USE CONTR | PIRLITE TO CALISE | OF DEAT | TLI VEC | ON D | | EDTAIN | | | | 1 | YES 2 NO |
| 4: The law cate has I State Dept | AN | 25. WAS CASE REFERRED TO MEDICAL | IDOTE TO CAUSE | | | (Check only o | | EKIAIIN | 1 1 | | | | |
| YSICIAN: The law requi s certificate has been s th the State Dept. of H d, or item 23 shov | PHYSICIAN: | EXAMINER? | HOSPITAL: | | | QTHER: | | - TILL - | | .= | | | |
| SICIA certif | Η̈́ | 27. MANNER OF DEATH | 28e. OATE OF INJUR | | 28b. TIME | | ome 5 Re | sidence (| | (Specify) | LILIBY OCCID | DEO | |
| T 7 5 8 | | Natural 5 Pending | (Month, Day, Year |) | INJU | RY | WORK? | ONE | 200. 000 | 5111DE 11011 III | 10011 0000 | HEO | |
| NDING I: After r deatl | D BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJUI | RY — At hor | ne, farm, str | | | 7.10 | 281, LOCA | TION (Street a | nd Number or | Rural Rou | tte Number |
| TTEN TOR. | ETEC | 4 Homicide detarmined | building, atc. (Sa | pecify) | | • | | | | r Town, State) | | | |
| L OR ATTENDING P. DIRECTOR: After the hours after death vitem 28 is mart | " | 29a, CERTIFIER CERTIFYING PHYSIC | CIAN: To the best of my kno | muladas des | db | | | | | | | | |
| R ZZ | COMPL | (Check only one) 2 MEDICAL EXAMINER | | | | | | | | | | | na minulio in mana |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 h IMPORTANT: If I | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | , in my opinion | | | | and place, end | 000 10 (110 | cause(s) e | nd menner sa stated. |
| 표 분들 | 8 | 290. SIGNATURE AND TITLE OF CENTIFIER | Being | M | | | | ENSE NUM | 1111 | | 29d. DATE S | BIGNED (M | forth, Day, Year) |
| ₽ P % ₹ | 유 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALLES OF | DEATH STEE | 27) /5 | Defeat) | 1 0 | 002 | . ~ | | | 0116 | 175 |
| | | | | | | 100 | | 100 | t | on 1/1 | ר ע | 1601 | 1 |
| | | Callum Bain, M 31. DATE FILED (Month, Day, Year) | D 415B | Last | DO∆ | er St | reet | <u>F</u> | Last | on, M | D Z | 1601 | ı |
| | | AUG 1 8 1995 | 137. REGISTRAN'S SIG | razila | Ц | | | | | | | | |
| | البسا | | | | | | | | | | | | |

| | | 1 - STATE OF MARYLAND / DEPARTMENT OF HE CERTIFICATE OF I | EALTH AND MENTAL HYGIENE DEATH REG. NO. | | | | | |
|-------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | |
| | | Deweese Medford Downes 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGF //n yrg (as) higher a year | August 8, 1995 11:15 P | | | | | |
| should | | 213-80-1797 1 M 2 F 60 YRS. MONTHS OAYS | F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) April 18,1935 Maryland | | | | | |
| 1, 2, 3 sho | CTOR | Corsica Hills Nursing Center Centrey | R LOCATION OF DEATH Ville Queen Annes | | | | | |
| Pages | DIREC | Maryland Caroline Ridgely | ON 10d. INSIDE CITY LIMITS? 1 YES 21/2 NO | | | | | |
| nsit permit. | FUNERAL | THE CONTRACT OF THE CONTRACT O | ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 21660 USA | | | | | |
| 1215-0020 or attending physician. r use as the burial-transit | BY | 1 To Never Married 2 Married FORCES? 1 YES 24 NO If yes, spec | ENDENT OF HISPANIC ORIGIN? (Specify Yee or No— city Cuben, Maxican, Puerto Rican, etc.) 2 X No Specify: Specify: Specify: Black | | | | | |
| (A = 5 | PLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) O 16e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) Never Worked | N 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| YLA by the be det | E COMPL | | 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Mary Grace Acree | | | | | |
| , MARY be retained by je 5 should by notified at | TO B | | nd Number or Rurel Route Number, City or Town, State, Zip Code) ager Road, Ridgely, Md. 21660 | | | | | |
| BALTIMORE, I er death. Page 6 may be the funeral director, page 4 val. | | 20a_METHOD OF DISPOSITION 1 \(\text{\(\)}}}}}} \) \end{\(\text{\(\text{\) \exiting{\(\text{\(\text{\) \exitin}}}}} \eximitinin \) \exiting \text{\(\text{\(\text{\(\text{\) \exiting{\(\text{\(\text{\) \exiting{\(\text{\(\text{\) \exiting{\(\text{\(\text{\(\)}}}}}} \end{\(\text{\(\text{\) \exiting{\(\text{\(\text{\) \exiting{\(\text{\init}}} \exiting{\(\text{\) \exiting{\(\text{\init}}}} \exiting{\(\text{\init}}}}} \exiting{\(\text{\init}}}} \exiting{\(\text{\init}}}}} \exiting{\(\text{\init}}} \exiting{\(\text{\init}}} \exiting{\) \exiting{\(\text{\init}}} \) \exiting{\(\text{\in | oate 20c LOCATION - City or Town, State 8/14/95 Greensboro, Md. | | | | | |
| BALTIMO after death. Page 6 by the funeral direct moval. cal examiner m | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND | D ADDRESS OF FACILITY Innie Smith Funeral Services | | | | | |
| BAL ter deal the fun wal. | | | D. Box 1687, Easton, Md. 21601 | | | | | |
| within thours within the hours remation, or re- | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode shock, or heart fellure. List only one cause on sech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): | de of dying, such ea cardiec or respiratory erreat, Approximete Interval Between Onset and Danth | | | | | |
| ficate be execuplysician and ne prior to burnet traumatic | ERTIFICATION | 0.112 = 0 1 - 0 00 = 1 2010 11 00 010 1 | | | | | | |
| D.S. P.C. the death certi the attending I Mental Hygie | CER | resulting in death) LAST | | | | | | |
| that the ed by the h and M | MEDICAL | PART II. Other algnificant conditions contributing to death but not resulting in the underlying | Couse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 AQ 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| r requirements | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | UNCERTAIN 1 YES WHO | | | | | |
| N: The law ricate has be State Dept. | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | |
| SICIAN: The Certificate the State | IXSI | 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home | 5 Residence 6 Other (Specify) | | | | | |
| 를 를 를 들 | ВУ РНУ | 1 Natural 5 Pending (Month, Day, Year) INJURY WORL 2 Accident Investigation | IK? ES 2 NO | | | | | |
| DIRECTOR: After hours after death item 28 is ma | ETED | 3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 로 경 등 등 | COMPLETED | 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of sxamination and/or investigation, in my opinion, dea | | | | | | |
| TO THE HOSPIT TO THE FUNER De filed within 7 | TO BE | ZF Cegane (M.) | 29d. DATE SIGNED (MONTY) Day, Year) 35-048 ≥ 8/8/9 | | | | | |
| | - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH-(YEM 27) (Type, Print) Eric F. Ciganek, MD. P.O. Box 339, Centre | eville, Md. 21617 | | | | | |
| | | AUG 17 1995 July Dischardall | | | | | | |



permit. Pages 1, 2, 3 should

page 5 should be detached for use as the burial-transit

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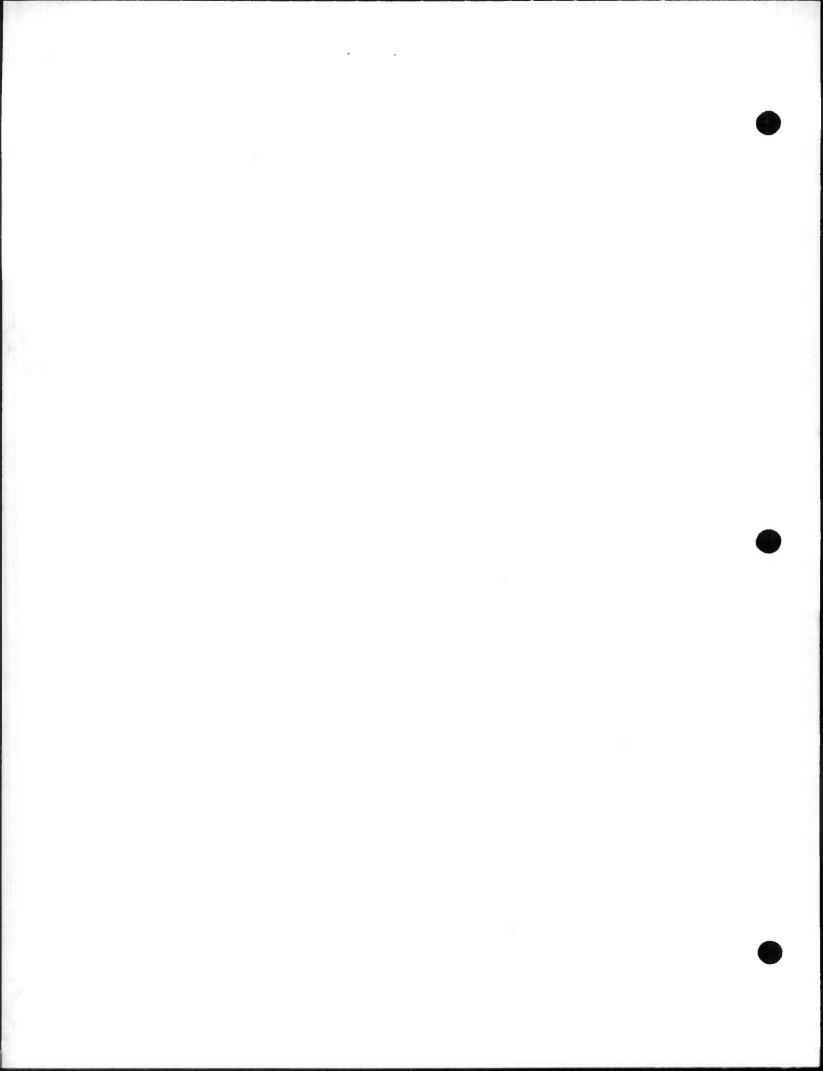
| CALLINO | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 m | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner mus |
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| | 400 | UNE | ANT |
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| | 2 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the label filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. | IM |
| | | | |

Amended #1, 8/16/95
- STATE BJV, Talbot C STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Emma Madeline Day 0940 August 1995 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, 'bear')
SEPT. 17, 1908 MARYLAND 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign Country) 1 M 2 XF DAYS 219-36-5078 YRS. 86 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR The Kent and Queen Anne's Hospital Ind Chestertown Kent RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND QUEEN ANNE'S CENTREVILLE 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? CORSICA NECK ROAD 21617 USA 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 22
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 TYES 2 NO Specify: Specify: 3 Widowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET tary/Secondary (0-12) College (1-4 or 5+) REGISTERED NURSE PUBLIC HEALTH DEPT. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) JOHN D. MOORE "UNKNOWN" BE BARBARA 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES R. GRISWOLD 19 FEDERAL ST., EASTON, MD 21601 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State riet 2 Cremetton 3 Removal from State CHESTERFIELD CEMETERY 8-18 4 Donation 5 Other (Specify) CENTREVILLE, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. HARRISON ST., EASTON, JOHN R 200 S. MERCEROD CESP 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition day ungestive resulting in death) DUE TO (OR AS A COL DUE TO (OR AS A CONSEQUE CERTIFICATION Sequentially ilst conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO hrun1 6 brunchi COMPLETION OF CAUSE 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Rasidence 6 - Other (Specify) 27, MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? Netural Accident 1 YES 2 NO м BY 28e. PLACE OF INJURY -- At home, term, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined П CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. COMPL (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF PERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 0 m 30. NAME AND ADDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH (ITEM 27) (Type, Print) 2

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32 REGISTRAR'S SIGNATURS

2.16



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and long after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be netified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Amender # 19 a, 8/30/95, LH., Frex. Co. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | ICATE OF DEATH | REG. NO. | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | 3. TIME OF DEATH |
| | HELEN PYLES DARBY | | AUGUST 22 | 1995 4:20 Am |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTNPLACE (State or Foreign |
| | 212-74-4314 1 M 2 🔼 F 82 YRS. | MONTHS DAYS HOURS MIN. | June 18 19 | 13 Maryland |
| OR | 98. FACILITY NAME (If not institution, give atreet end number) 1400 Homecrest Rd. / Apt.57 | Silver Spring | | county of DEATH |
| DIRECTOR | | y, TOWN OR LOCATION | | 10d. INSIDE CITY |
| | Md. Montgomery 100. STREET AND NUMBER | Silver Spr: | | t YES 2 □ NO CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 14400 Homecrest Rd. / Apt.57 | 20906 | U | .S.A. |
| B≺ | tt. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 M NO Speci | en, Puerto Ricen, etc.) | 14. RACE — American Indian, Black, White, etc. Specify White |
| | (Specify only highest grade completed) (Give kind of v | USUAL OCCUPATION work done during most of working | 166. KIND OF BUSINES | S/INDUSTRY |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 +) | teacher | Montg. Co | . Board of Ed. |
| O | 17. FATNER'S NAME (First, Middle, Last) | 18. MOTNER'S N | AME (First, Middle, Meiden Surna | me) |
| BE C | Walter W. Pyles | Emma | a Williams | |
| 10 | | ADDRESS (Street and Number or Flural Box 590 Olney | | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF | OF DISPOSITION (Name of | | PN — City or Town, State |
| | 4 Donation 5 Other (Specify) | ther place) | 8/25 Beall | sville, Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF F | ACILITY | |
| - 6 | W/m C Kett | Hilton Fur | neral Home Le, Md. 208 | 38 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do n shock, or hasnt failure. List only one cause on each line. | ot enter the mode of dying, su | ch ss cardisc or respirator | y srrest, Approximats |
| | IMMEDIATE CAUSE (Final | 4- / | | Interval Between Onest and Death |
| | disease or condition resulting in daeth) a. JNANUTIO DUE TO (OR AS A CONSEQUENCE OF | 7): | | MONTHS |
| NO | Sequentially list conditions, b. DEHYDIZA | | | MONTHS |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | f): | | |
| IFIC | CAUSE (Disesse or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF | 7): | | |
| ERIT | resulting in desth) LAST | | | |
| | PART II. Other significant conditions contributing to deeth but not resulting I | n the underlying ceuse given in | Part I. 24s. WAS AN AUTO | PSY 24b. WERE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICAL | | | PERFORMED: | AMILABLE PRIOR TO |
| I: ME | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | F DEATH YES N | 0 124 | 1 TES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (C | heck only one) | |
| Sic | t YES 2 NO 1 Inpetient 2 FR/Outpetient 3 DOA | OTHER: 4 Nursing Nome 5 Residence | 6 Other (Specify) | |
| F | 27. MANNER OF DEATH 268. DATE OF INJURY (Month, Day, Year) INJ | | 28d. DESCRIBE NOW INJUR | Y OCCURED |
| B | 1 Netural 5 Pending 2 Accident Investigation | M 1 YES 2 NO | | |
| TED | 3 Suicida 6 Could not be 4 Nomicide datarmined 28e. PLACE OF INJURY — At home, tarm, so building, atc. (Specify) | treet, factory, offica | 26t, LOCATION (Street and No City or Town, State) | imber or Rural Route Number, |
| COMPLETED | 29s. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred one) | | | |
| Ö | 2 MEDICAL EXAMINER: On the bests of axamination and/or investigation | n, in my opinion, death occured at the | time, data and place, and due | to the cause(s) and manner as stated. |
| 띪 | 296. SIGNATURE AND TITLE OF CERTIFIER DOLL HOUTH AND - PHY | SICIAN D379 | MBER 294 | DATE SIGNED (Morith, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. 18(1) Dr. #3 | Print) 12 OWEL | . 440 | 20025 |
| | 31. DATE FILED (Month, Day, Year) 32. RPGISTRAPIS SIGNATURE | ic ouve | (MD) | 60832 |
| | ALIG 2 8 1995 Sala d'avelor Rail 10 | (| | |

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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | | YGIENE EG. NO. | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) | N | Do | 11/2 | | 2. DATE OF C | DAY | 3. TIME OF OEATH |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| (In yrs. last birthday) | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DAYL OF B | HRTN | 995 11:06 AM BIRTHPLACE (State or Foreign |
| Pi | | 217-34-1369 | 1 X M 2 □ F 5 | 9 YRS. | DAYS | HOURS MIN. | | 0,1936 | Maryland |
| 2, 3 should | OR | 96. FACILITY NAME (If not institution, give str Shady Grove Adv | | spital | | or location of o | | | TY OF GEATH |
| Pages 1, | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | and the second | , TOWN OR LOCAT | | | | 10d. INSIDE CITY |
| permit. Pa | | Maryland Mont | tgomery | | Rockvi. | | | | PE YES 2 NO |
| ISI | ERAI | 49 Moore Drive | | | 101 | 20850 | | 1.000 | U.S.A. |
| 215-0020 attending physician. se as the burial-transit | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENDENT OF HISPAI ecity Cuban, Mexica 2 NO Specif | in, Puerto Rican | pecify Yee or No- | 14. RACE — American Indian, Black, White, ptc. Specify: Black |
| 5 | ED | 15. OECEDENT'S EOUC (Specify only highest grade | completed) | 16e. DECEDENT'S I (Give kind of w life. Do NOT use | ork done during mo | | 16b. KIN | D OF BUSINESS/INDU | STRY |
| the hospital of detached for | COMPLET | Elementary/Secondary (0-12) 8th | College (1-4 or 5+) | | scaper | | L | andscape | |
| 7LAN by the hos be detach | | 17. FATHER'S NAME (First, Middle, Last) Louis Watkins | | | | | | , Malden Surname) | |
| MARYLAND retained by the hospit 5 should be detached | | 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILINO | ADDRESS (Street e | | inia l | ity or Town, Statu, Zip (| Code) 20877 |
| E, M y be ret y age 5 s | | Nathaniel Magrı | | | | | .,#20 | | ersburg,MD |
| ORE 6 may rector, pa | | 20a. METNOD OF DISPOSITION LA Burlel 2 Cremation 3 Remo 4 Donation 6 Other (Specify) | val from State 20b | Gate of | FDISPOSITION (Na Heaver | n Cem. | 8/21 | Silver | ty or Town, State Spring, MD |
| 2 6 6 6 8 | | 21. SIGNATURE OF FUNERAL SERVICE LIG | | bla | _ | | NERAL | HOME, P | .A. |
| 0 = 6 | | Storge K | - Juon | Rey | | KVILLE, | | 20850 | |
| - Nous | | 23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition | lat only one ceuse on e | ech line. | ot enter the mo | 1 | 0 | 1 | Approximate interval Between Onset and Death |
| d within 24 ompletely fille 1, cremation, the | | resulting in death) | DUE TO (OR AS A | CONSEQUENCE OF |): | - Carce | hy | Laron | a 5 min |
| OX 687 be executed sician and confor to burial, trainmattic, and the conformattic, and the conformation and the conforma | NO. | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | yora | thy | | | 724Rs |
| AA 2 6 0 | ICAT | cause. Enter UNDERLYING CAUSE (Disease or Injury | Cole | man | jar | ferry | dis. | ease | 7542 |
| P.O. E th certifica anding phy Hygiene I | CERTIFICATION | that initiated events resulting in death) LAST | ENA | Dhus | emo | 2 | | | >5 us |
| DS, I the death the atte d Mental | L CE | PART II. Other algnificent conditions | contributing to death b | out not reaulting is | n the underlying | g cause given in | Part I. 24a | . WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| the | | | | | | | 1 | PERFORMED? YES 250 NO | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | . ME | DID TOBACCO USE CONTR | BUTE TO CAUSE C | DE DEATH YES | S M NO F | UNCERTAII | N [| | 1 TES 2 NO |
| ITAL I: The law cate has t State Dept item 23 | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATI | H (Check only one) | ORCERIAN | | | 1 |
| | HYSI | 1 TYES 2 % NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outp | petient 3 DOA | | e 5 Residence | | ecify) BE NOW INJURY OCCU | laca . |
| NG PHYS | BY PI | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | MJU | JRY WO | PK? | 200. DESCRIE | E NOW INJUNY OCCU | RED |
| TTENDI TTENDI STOR: A after de | 8 | 3 Suicide 6 Could not be 4 Nomicide determined | 26e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, at cify) | treet, lactory, office | • | 261. LOCATION City or Tox | N (Street and Number of wn, State) | · Rural Route Number, |
| Z 70 = | | | CIAN: To the best of my know R: On the bests of examination | | | | | | f. cause(a) end menner se stated. |
| TO THE HOSPIT TO THE FUNERA be filed within 7 | BE C | 296. SIGNATURE AND TITLE OF CHATIFIER | 0/20/20 | | | 29c. LICENSE NUI | WBER | 29d. DATE : | SIGNED (Morith, Day, Year) GUST-17-1995 |
| 888 | 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATN (ITEM 27) (Type, | Print) | D32 | 174 | | |
| 5 | | SISUDHAKAY | | | CONSTE | NDR. | #50 | 4, K, N | D.20852. |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | ATURE | | , | | | |

5290.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the fleath. Page 6 may be retained by the hospital or attending physician.

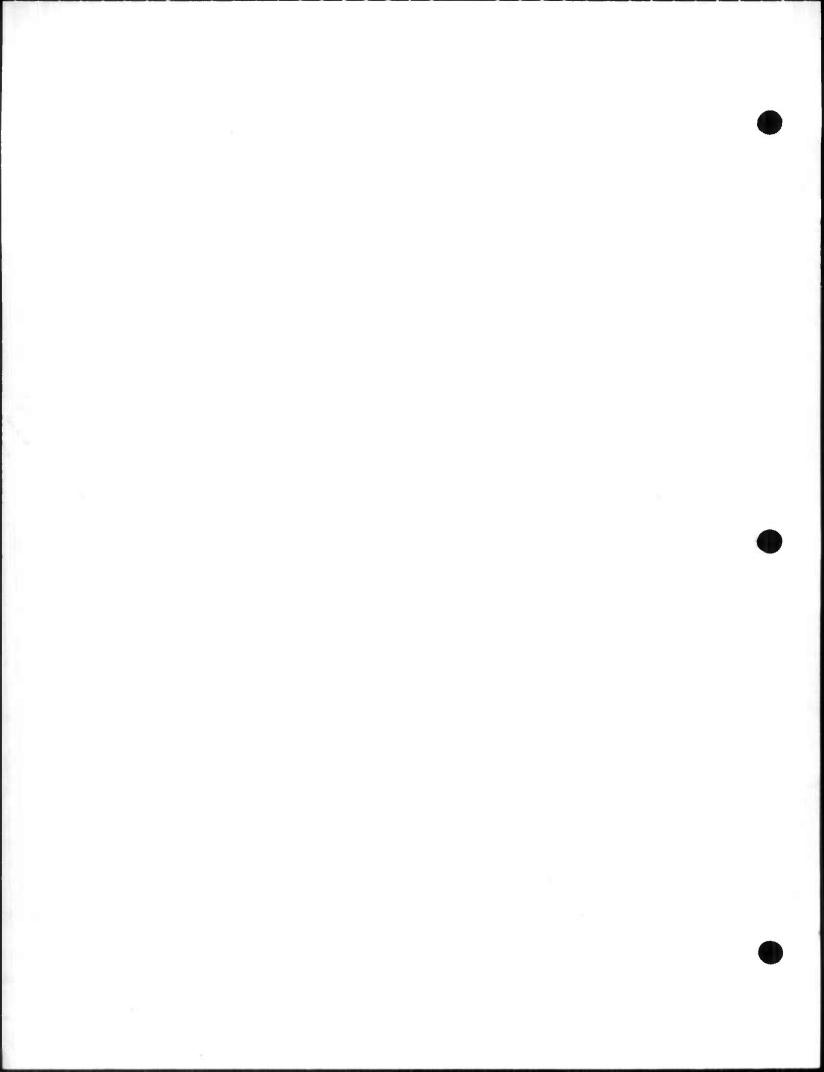
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competely filled in by the funeral directic, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, | 4.02-4-00- 4 | | | | | 01111 | - 01 | DEA | | HEG. P | 0. | | |
|---------------------|----------------------------------------------------------------|--------------------------|---------------------------|-------------------------------|------------|-------------------|--------------------------------------------------------|----------------|----------------------|----------|-------------------------------------------|---------------------|---------------|----------------------------------------------|
| | | | Jose Do | C = 20m = | | | | | | | 2. DATE OF DEATH MONTH | DAY | YEAR | 3. TIME OF DEATH |
| | | | | | | | | | | | August 1 | 7,199 | 95 | 9:30 P m |
| | 4. SOCIAL SECURITY NUMBER None | ER | 5. SEX 1 ☐ M 2 🔽 F | 6. AGE (In | | | IF UNDER | 1 YEAR DAYS | /Mor | | (Month, Day, Year) Coul | | Countr | PLACE (State or Foreign y) |
| | 9e. FACILITY NAME (If not institution, give street and number) | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT | | | | | | | |
| œ | 6524 Lone Oa | | | | | | | | | | tgomery | | | |
| 읽 | RESIDENCE OF DECEDENT | | | | | | De chesua Montego. | | | | tgomer y | | | |
| Ä | 10e. BTATE 10b. COUNTY | | | | | 10c. CITY, | , TOWN C | OR LOCAT | ION | | | | | 10d. INSIDE CITY |
| 8 | Maryland Montgomery | | | | | | Bethesda | | | | | LIMITS? | | |
| AL | 10e. STREET AND NUMBER | | | | | | | 101 | . ZIP CODE | | | 10g. CI | TIZEN OF W | HAT COUNTRY? |
| EB | 6524 Lone Oak Court | | | | | | | | 208 | 17 | | Por | tuga | L |
| BY FUNERAL DIRECTOR | 11. MARITAL STATUS | | 12. WAS DECEDER | T EVER IN U | U.S. ARME | ED | 13. | WAS DEC | ENDENT O | F HISPAN | IC ORIGIN? (Specify | fes or No- | 14. RACE | — American Indian, White, atc. |
| <u>-</u> | 1 Never Married 2 I | | FORCES? | | | | | | ecify Cuba 2 🙀 NO | | n, Puerto Ricen, etc.) | | Speck | |
| | 3 🔀 Widowed 4 🗌 Divon | ced | | | | | | | X | | | | | White |
| 岜 | | DENT'S EDUC. | | , | | EDENT'S U | | | ON st of workin | a | 16b. KIND OF | USINESS/IN | DUSTRY | |
| Ü | Elementary/Secondary (0- | 12) | College (1-4 or 5 | +) | Ilfe. D | NOT use | retired.) | | | | | | | |
| COMPLETED | 3 | | | | F | 'arme | er | | | | Fa | rming | J | |
| 8 | 17. FATHER'S NAME (First, Mic | 31 1 | | | | | | | | | ME (First, Middle, Maid | | | |
| BE | Joao d | | no | | | | | | | | Francisca | | | |
| 2 | 19a. INFORMANT'S NAME (Ty) | | | | | | | | | | Route Number, City or 1 | | | LI JULIUS JEJ |
| | Maria Odete | | iro | | | | | | | | Bethesda, | | | 20817 |
| | 20a. METHOD OF DISPOSITION DISPOSITION 2 □ Cremetion | 3 🗌 Remo | val from State | 20b. P | PLACE AN | D DATE OF | F DISPOS | ITION / | ugus | | DATE 20c. | LOCATION - | - City or To | wn, State |
| | 4 Donation 5 Other | , , , , , | | Fa | ro (| itory or oth | | | | 1995 | - ' | | Portu | |
| | 21. SIGNATURE OF FUNERAL | SERVICE LICE | ENSEE | 17 | | 240 | Ho | me/E | ethe | sda- | Chevy Cha | se,] | Inc., | rey Funeral 7557 |
| | 23. PART I. Enter the dis | les | 7-14 | (R) | | 348 | Wi | scon | sin | Ave. | , Betheso | a, Ma | arylaı | nd 20814 |
| | ahock, or he IMMEDIATE CAUSE (Fine disease or condition | art fellure. L | lat only one cer | use Dn eac | ch line. | _ | | the mo | an or ayı | ng, sucr | a a cardiac or re | piratory a | rreat, | Approximate interval Between Onset and Death |
| - | resulting in death) | → | DUE TO | OR AS A C | ONSEGUI | the of | ma | md | 1 | TVV | للحق | | | |
| _ | | _ | 000 10 | A N | ONSEGU | ENCE OF | 1 | 1 | 0 | | | | | |
| CERTIFICATION | Sequentially flat condition | | DUE TO | (OR AS | ONSEOU | ENCE OF | ا: ح | باوج | 200 | 2 | | | | |
| A | If any, leading to immed cause. Enter UNDERLYIN | IG | | | | | | | | | | | | Ì |
| Ĕ | CAUSE (Disease or Injur that initiated events | y | DUE TO | (OR AS A C | ONSEOU | ENCE OF) | : | | | | | | | |
| F | reaulting in deeth) LAST | d. | | | | | | | | | | | | |
| | PART II Other elgolfices | t conditions | apatribution to | double but | | udat - t - | | 4 4 4 | | | | | | |
| EDICAL | PART II. Other algnifican | it conditions | contributing to | deeth but | not rea | ulting in | 1 the un | deriyin | g cause g | Iven In | | N AUTOPSY DRMED? | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| ŏ | | | | | | | | | | | 1 _ YES | 2 1 NO | | COMPLETION OF CAUSE OF DEATH? |
| M | | | | | | | | | / | | _ | | | 1 YES 2 NO |
| Z | DID TOBACCO US | | IBUTE TO CA | | | | | | UNC | ERTAIN | 1 🗆 | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO EXAMINER? | - | HOSPITAL: | 28 | B. PLACE | OF DEATH | OTHER | - | | | | | | |
| YS | 1 TYES 2 THO | | 1 inpatient 2 | | | DOA | 4 🗌 Nun | | 5 DA | sidence | 6 Other (Specify) | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 P | endina | 28e. DATE OF (Month, L | | 1 | 28b. TIME INJU | | | RK? | | 28d. DESCRIBE NO | INJURY O | CCURED | |
| À | | vestigation | | | | | M | | 'ES 2 [| NO | | | | |
| TED | | ould not be elermined | 28e. PLACE (building, | of INJURY — atc. (Specify) | - At home | e, ferm, et | reet, fact | ory, offic | | | 28f. LOCATION (Stre- City or Town, Ste | | er or Rural A | oute Number, |
| COMPLET | 29a. CERTIFIER (Check only | FYING PHYSIC | IAN: To the best of | my knowled | ige, death | occurred | at the ti | me, data | and place | and due | to the cause(s) end n | anner en et | stad | |
| M | | | | | | | | | | | | | | and manner as stated. |
| _ | 29b. SIGNATURE AND NILE | | | | | | | | | NSE NUM | | _ | | |
| BE | | | | 9- | > | | | | | 9960 | DER | 29d. DA | D A | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAU | SE OF DEAT | N (ITEM 2 | 27) (Type 4 | Print) | | 0 | 7700 | | | 0/1/ | N |
| | Paul | Peel | les.19 | Dis | 561. | 25 | | Ce | Isac | Ao | e, Be | Lesd | a M | 120814 |
| | 31. DATE FILED (AUG) 2 | I 1995 | 32. BEGISTRA | P'S SIGNATI | URE | fall | 1 | | | | , | | - | |



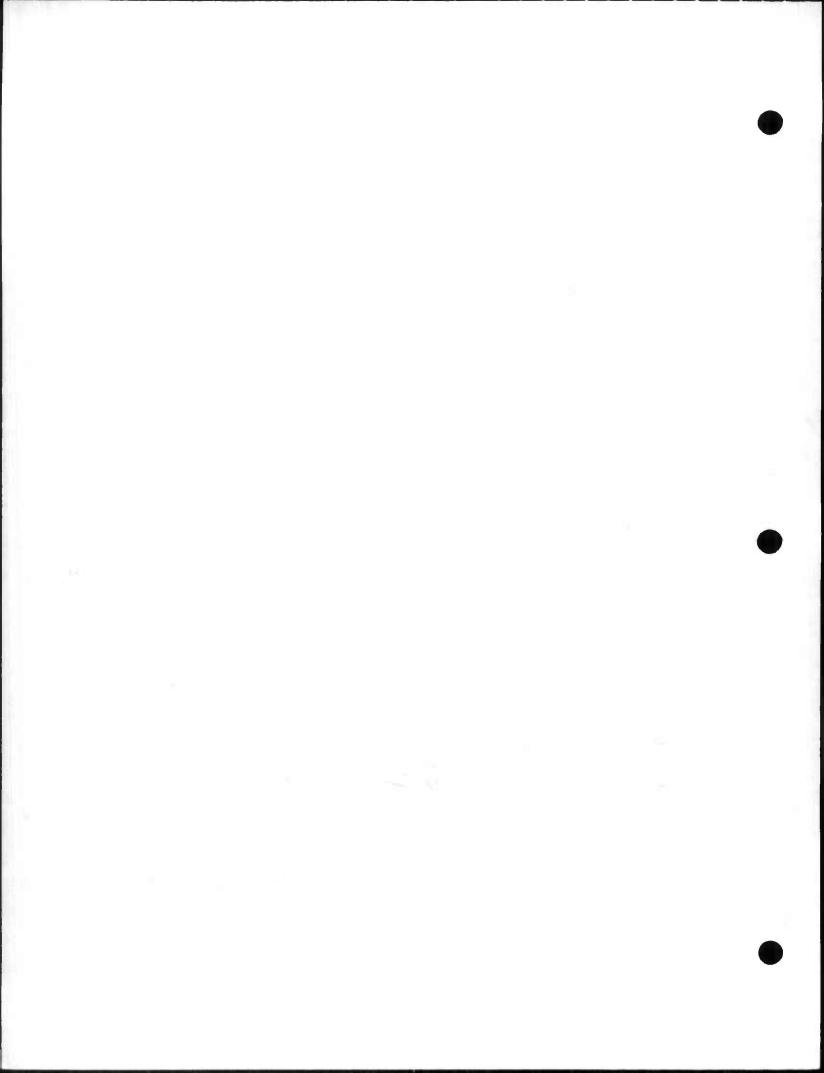
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | IEALTH AND M | HENTAL HYGIEN | | |
|------------------|------------------------------------------------------------|----------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------|-------------------|--------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | | 3. TIME OF DEATN |
| | Ruth | G | ale | D | مدرع | August, | | IIII AM |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 0. BI | IRTNPLACE (State or Foreign |
| | 579-32-7706 | 1 M 2XXF 79 | YRS. | MONTHS DAYS | HOURS MIN. | June 28, 1 | | hicago, Ill. |
| ~ | 9a. FACILITY NAME (If not institution, give a | | | | OR LOCATION OF DEA | NTN | 9c. COUNTY C | F DEATN |
| ١٥ | Montgomery Gen | eral Hospital | - | 01n | ey | | 2083 | 2 |
| DIRECTOR | 10e. STATE 10b. COUNT | Y | 10c. CITY | TOWN OR LOCAT | TION | | | 10d. INSIDE CITY |
| 5 | MD Mon | tgomery | 0 | lney | | | | XX YES 2 NO |
| A | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZEN C | OF WHAT COUNTRY? |
| FUNERAL | 18430 Brooke G | rove Road | | | 20832 | | Unite | d States |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | | | ENDENT OF NISPANIO | C ORIGIN? (Specify Year | or No- 14. R | ACE — American Indian, Black, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR DR DA | | | 2 NO Specify: | | | Specify: |
| | 15. DECEDENT'S EDU | | 18e. DECEDENT'S L | | | 16b. KIND OF BUS | SINESS/INDLISTS | White |
| E | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of we | ork done durina ma | st of working | | | |
| MPL | | +2 | Home | maker | | Ног | usewife | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAM | E (First, Middle, Maiden | Surname) | |
| 8 | Charles Gale | | | | Hele | | | Gale |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Deborah Davis | T offunors | | | | oute Number, City or Town | |) |
| | 20e. METHOD OF DISPOSITION | | 16200 | J Deer I | Jake Road | , Derwood, | | 0855 |
| 1 | Burlel 2 Cremetion 3 Rem | | | | me of 8/20/9 | | CATION - City o | rch, VA |
| | 21. SIGNATURE OF FUHERAL SERVICE LIC | DENGEE / / | ng David | 7 22. NAME AT | 1 Garden | LUTY | | ich, va |
| | Frant An | 1+- X100 | mond | | | Funeral H | | |
| \vdash | 23: PART I. Enter the disesses, or o | complications that caused | the death Do no | 11800 | New Ham | pshire Ave | Silver | r Spring MD |
| | snock, or heart fellure. | List only one cause on es | ch line. | n enter the mo | ae or aying, such | as cardiac or reapi | ratory arreat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finei disease or condition | Q. | - 4 | | 2 1 | | | Onset and Death |
| 1 1 | resulting in death) | B. DUE TO (OR AS A | CONSEQUENCE OF | - | E 65-7 | ave | | Sures |
| z | • | 800 | - 200 (| 8 | a for it | - | | 24 hus |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF) | | | | | |
| 2 | CAUSE (Disease or Injury | C | | | | | | |
| Ë | that initiated eventa resulting in death) LAST | DUE TO (OH AS A | CONSEQUENCE OF) | | | | | i 1 |
| S | | d. | | | | | | - |
| AL | PART II. Other significant condition | | t not reaulting in | the underlying | cause given in P | art 1. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| PHYSICIAN: MEDIC | 4000 | uned | 4.6 | | | 1 YES 2 | Duo | COMPLETION OF CAUSE OF DEATH? |
| M | DID TODA COO HIST COA | | | | | | | 1 YES 2 NO |
| AN | DID TOBACCO USE CONTI | | | | UNCERTAIN | | | |
| SICI | EXAMINER? | HOSPITAL: | | OTHER: | | | | |
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| Ē | 4 Homicide determined | building, etc. (Special No. 1995) | | Hom - | | City or Town, State) | | asi Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only | CIAN: To the best of my knowle | | | | | | 2 3 10 10 |
| MO | one) 2 MEDICAL EXAMINE | R: On the beats of examination | and/or investigation | in my opinion, de | eath occured at the tie | me, date and place, and | d due to the caus | ie(a) end menner es stated. |
| Ü | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMB | | | IED (Month, Day, Year) |
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| 2 | 30. NAME AND ADDRESS OF PERSON WH | D COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, F | and the same of th | | Beth | A. | W.S. |
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| | AUG 21 1995 | 32. REGISTRAR'S SIGNA | | | | | | |
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| the hospital or attending physician, | detached for use as the burial-transit permit. Pages 1, 2, 3 should | l once. | |
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| 0 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 2 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires th | O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fure filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. | APORTANT: If item 28 is marked, or item 23 shows an | |

| Hidde K. Davies A Dodge | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIE | | | |
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| 198. BROTHMANT'S NAME (Pyparfirst) Linda L. Nowak 10 Method of Department of Phasmas and Pound Number (Dy or Burn, Stein, Zie Code) Linda L. Nowak 10 Method of Department of Phasmas and Pound Number (Dy or Burn, Stein, Zie Code) 10 Method 2 Si Crempton 1 Removal from State 20 Name And Name and Department of Phasmas 20 Name And Name and Phasmas 20 Name And Name and Name and Phasmas 20 Name And Name a | | | | | | | | n Surname) | | |
| Linda L. Nowak 5431 Autumnfield Court, Ellicott City, MD 21043 300. METHOD OF DIRPORATION 10 Burle 12 Computer Premoval from State | 20 | | | | | | | | | |
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| 23. PARTYL Enter the diseases, or complications with caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one couse on each line. MMEDIATE CAUSE (Final diseases, or complications with caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batween ones of conditions, and conditions, | | 1 Burlet 2 10 Cremation 3 Rer | noval from State Ceg | PLACE AND DATE OF I betery, crematory or other | place) | ame of | | | | |
| 1800 New Hampshire Avenue Silver Spring, Maryland 20904 22. PARTYL Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Interest Cause) a. Coinaly then disease or condition resulting in death) DUE TO (OR AG NOSSOURES OF): a. Coinaly then disease or conditions of arrived and Death DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of arrived and Death DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of arrived and Death DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of arrived and Death DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinaly the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinal the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinal the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinal the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinal the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): a. Coinal the conditions of a disease or injury DUE TO (OR AG NOSSOURES OF): DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES AND UNCERTAIN DESCRIPTION OF OR AGE DUE TO (OR AG NOSSOURES OF): DID TOBACCO USE CONTRIBU | - 1 | The state of the s | | ort Linco. | | | | | | |
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| Approximate makes a complications that cause on each line. MMREDIATE CAUSE (Final disease or conditions resulting in death) DUE TO (on A & COMSCOURCE OP): Sequentially list conditions, any, leading to immediate cause. Enter UNDERLYING that interest and Datth one of the property of the cause of the Congress of the | _ | Mesunt. | Tokelhuy- | | Silv | er Sprin | g, Marylar | d 209 | 904 | |
| PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 246. WAS AN AUTOPSY PROPORTION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO U | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events List only photocause on each line. Interval B Onset and Congettive | | | | | | | Interval Batween | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINERY 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Noptimit 2 ENJOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH (Month, Dey, Year) 28. DATE OF INJURY 2 St. INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY 2 St. INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. LOCATION (Street and Number or Rural Route Number, City or Rown, State) 29. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and menner as stated. 29. MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29. FUNCTION (Street and Number or Rural Route Number, City or Rown, State) 29. MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29. FUNCTION (Street and Number or Rural Route Number, City or Rown, State) 29. MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29. DATE SIGNED (Month, Dey, Year) 29. DATE SIGNED (Month, Dey, Year) | AL C | PART II. Other algorificant condition | na contributing to deeth b | ut not reaulting in t | he underlyin | g ceuse given in | DEDE/ | - DAREDO | 24b. | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINERY 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Noptimit 2 ENJOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH (Month, Dey, Year) 28. DATE OF INJURY 2 St. INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY 2 St. INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. LOCATION (Street and Number or Rural Route Number, City or Rown, State) 29. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and menner as stated. 29. MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29. FUNCTION (Street and Number or Rural Route Number, City or Rown, State) 29. MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29. FUNCTION (Street and Number or Rural Route Number, City or Rown, State) 29. MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29. DATE SIGNED (Month, Dey, Year) 29. DATE SIGNED (Month, Dey, Year) | 5 | | | | | | 1 YES | 2 X 10 | | |
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| 27. MANNER OF DEATH Natural S Pending Investigation 28a. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 1 YES 2 NO 28b. DESCRIBE HOW INJURY OCCURED | Ž | | | | | UNCERTAI | N | | | |
| 27. MANNER OF DEATH Natural S Pending Investigation 28a. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 1 YES 2 NO 28b. DESCRIBE HOW INJURY OCCURED | 3 | EXAMINER? | | | | | | | | |
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| 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, ferm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29e. CERTIFFIER (Check only 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. CERTIFFIER (Check only 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. CLICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Mont | | 1 | | | | | 28d. DESCRIBE HOW | INJURY OCCU | JRED | |
| 4 Homicide determined building, stc. (Specify) 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end dua to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 29b. GRATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM, 27) (Typa, Print) SWATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | ā | 2 Accident Investigation | | | | | | | | |
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| 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) and manner as stated. 29b. CHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) August 21, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM, 27) (Type, Print) Swith 5-to 7610 Carrollave the Signature 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) August 21, 1995 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | 29a. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my knowl | edge, death occurred a | t the time, date | end place, end due | to the cause(s) end m | enner en state | d. | |
| 296. GRATUBE AND TITLE OF CENTER 296. LICENSE NUMBER 296. DATE SIGNED (Morith, Day, Your) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM, 27) (Typa, Print) SNUTH S. HO 7610 Cayroll Avc + 260 Teknowa Park Maryland 20 917 31. DATE FILED (Morith, Day, Your) 32. REGISTRAR'S SIGNATURE | 5 | | | | | | | | |) and manner as stated. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM, 27) (Typa, Print) SNUTH S. HO 7610 Carroll Ave + 260 Telegoma Park Maryland 20 912 31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE | } | | | | | | | T | | |
| Smith S. Ho 7610 Carroll Ave # 280 Tekoma Park Maryland 20912 | 5 | Attuille S. M. | | | | D216 0 | | > .//. | SIGNED | LOI 100 V |
| Smith S. Ho 7610 Carroll Ave # 280 Tekoma Park Maryland 20912 | 2 | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE OF DE | ATH (ITEM, 27) (Type, Pri | nt) | V-470 | 1 | 771 | que | 7 41/743 |
| | | Smith S. Ho 761 | 10 Carroll Av | 1c#280 | Tekon | ia Pari | k Mary | and | 2 | 0912 |
| | | | | Rody | | | V | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

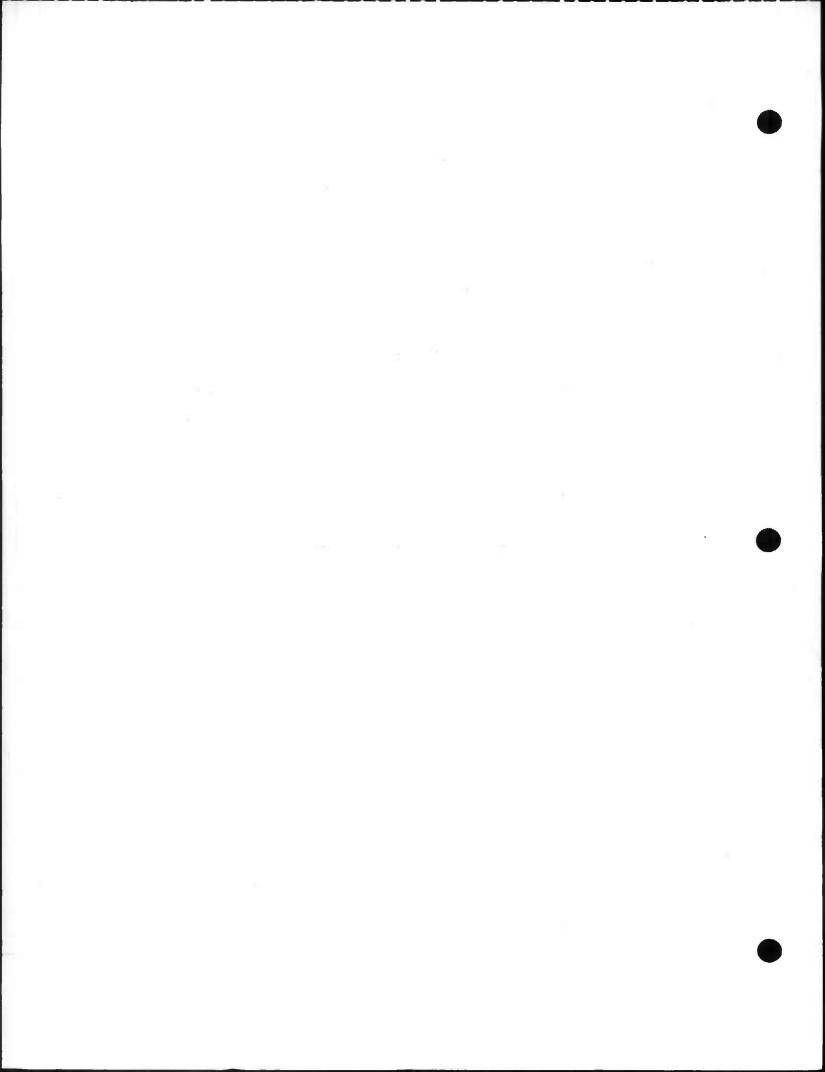
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 | • | FOR STATE REGISTRAR |
|---|------|---------------------------|
| Г | 1. 0 | ECEDENT'S NAM |

| | REGISTRAR | | | CHIL | ICALE | OF | DEAL | | H | REG. NO. | | | |
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| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF I | DA | | YEAR | 3. TIME OF CEATH |
| | | MENT FORT | | | | | , | | | AUG 20 1995 9:30 1 | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | | IF UNDER 1 | YEAR DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE OF E (Month, De | | | 8. BIRTHP Country | LACE (State or Foreign |
| | 314-14-5086 | | | | | | | | Feb. 24, 1924 | | | Indiana | |
| 00 | 9e. FACILITY NAME (If not institution, give street and number) | | | | | | OR LOCATIO | | ATH | | 9c. COUNTY OF OEATH | | |
| 5 | NATIONAL NAVAL MEDICAL CENTER | | | | | Bl | ETHES | DA_ | | | MONTGOMERY | | |
| DIRECTOR | 10a. STATE 10b. COUNT | r | | 10c. CIT | TY, TOWN OR LOCATION 10d. IN: | | | | | 10d. INSIDE CITY | | | |
| 뜸 | Maryland | Si | Silver Spring | | | | | | 1 📆 YES 2 🗍 NO | | | | |
| | 10e. STREET AND NUMBER | 1 01. | LVCI | \rightarrow | ZIP COOE | | | | 10g. CITI | AT COUNTRY? | | | |
| FUNERAL | 3808 Greenly Stre | et | | | | | 20 | 906 | | U.S.A. | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. W | AS DEC | ENDENT O | F HISPAN | IC ORIGIN? (S | pecify Yes | | 14. RACE | - American Indian, |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | | YES 2 WAR OR DATES | NO | | | ecify Cuber 2- NO | | n, Puerlo Ricar | n, etc.} | | Black, Specify | White, etc. |
| | | 1943- | -1967 | | | | Δ. | | | | | Wh | ite |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 1000 | DECEDENT'S (Give kind of v | work done du | | | g | 16b. KIN | D OF BUS | INESS/IND | DUSTRY | |
| <u>"</u> | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | life. Do NOT us | | | | | 1 | | | | |
| N N | 12 17. FATHER'S NAME (First, Middle, Last) | | Te | chnica | al Wr | ite | | | | S. N | | _ | |
| | The second secon | | | | | | | | WE (First, Middle | | Sumame) | | |
| H | Dominic DeVit 19a. INFORMANT'S NAME (Type/Print) | a | | 401 444 1110 | | | | ılu | Oute Number, C | iven | | | |
| 임 | Virginia M. DeWi | | | | | | | | | | | | 1 20006 |
| | 20a, METHOD OF DISPOSITION | | | _ | | | | | - | | | City or Tow | and 20906 |
| | 1 Special 2 Cremation 3 Rem | oval from State | cemetery c | cremetory or o | ther place) | | nne or | 8/ | 28/95 ry | | | | rginia |
| | 21. SIONATURE OF FUNERAL SERVICE LIC | ENSEE | ALLI | ngcon | 22. N | AME AN | ID ADDRES | S OF FAC | M ITY | | | | |
| | Francis J. Collins Funeral Home, Inc. | | | | | | | | | | | | |
| _ | Matthew | Vik | | | 50 | 0 U | nive | rsit | y Blvd | .,W. | Sil. | Spr. | ,MD 20901 |
| | 23. PART I. Enter the diseeses, or shock, or heart fellure. | complications the List only one ceu | t ceused the dise on each lice | deeth, Dor ne. | not enter t | he mo | de of dyl | ng, auch | aa cardlec | or reapi | ratory arr | reat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | 141 | | | | | | | | | | Onset and Death |
| | reaulting in death) | • | TAGE CH | | | RUC | CTIVE | PUL | MONARY | Z DIS | EASE | , | |
| | | DUE TO | (OR AS A CONS | SECUENCE OF | F): | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, | bDUE TO | (OR AS A CONS | EQUENCE OF | F): | | | | | | | | |
| Ä | If any, leading to immediate cause. Enter UNDERLYING | | | | • | | | | | | | | İ |
| Ē | CAUSE (Disease or Injury thet initieted events | DUE TO | (OR AS A CONS | EQUENCE OF | F): | | | | | | | | |
| F | resulting in death) LAST | d | | | | | | | | | | | |
| | PART II. Other significant condition | e contribution to | double had not | Calculation . | | -4.6- | | | | | | | |
| EDICAL | TATT II. OUT SIGNIFICANT CONDITION | s contributing to | Geetii Dut noi | resulting i | in the unu | eriying |) cause g | iven in i | Pert I. 24a | PERFOR | | | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| ă | | | | | | | | | 10 | YES 2 | ĭ NO | | COMPLETION OF CAUSE OF DEATH? |
| Σ | | | | | | | | | | | | 1 | YES 2 NO |
| AN | DID TOBACCO USE CONT | KIBUTE TO CA | | | | | UNC | ERTAIN | 1 🗆 📗 | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | ACE OF DEAT | OTHER: | ny one) | | | | | | _ | |
| ¥ ∥ | 1 YES 2 NO 27. MANNER OF DEATH | 1 X Inpatient 2 | | 3 DOA | | | e 5 🗆 Red URY AT | sidenca | 6 Other (Sp. | | | | |
| ā | 1 X Natural 5 Pending | (Month, D | ay, Year) | | URY M | WO | RK? | I NO | 28d. DEŞCRIE | BE HOW IN | IJURY OCC | CURED | |
| BY | 2 Accident Investigation 3 Suictde & Could not be | 28a, PLACE O | F INJURY — At I | home farm s | treet factor | | | NO | 26f. LOCATIO | Al /Cimal a | nd Mumbas | or Premi Do | the Million beautiful and the Control of the Contro |
| COMPLETED | 4 Homicide 6 Could not be | building, | etc. (Specify) | | | ,, | | | City or To | wn, State) | no momber | or norm no | ore rromber, |
| 9 | 29a. CERTIFIER AVI APPRIENTING BUILDING | | | | | | | | | | | - | |
| MP | 29e. CERTIFIER (Check only one) 1 X CERTIFYINO PHYSI | | | | | | | | | | | | COLUMN TO THE STATE OF THE STAT |
| 응 | | | ABITITION BINGS | - IIIvvatigatio | ii, iii iiiy opi | mon, o | | | | piece, en | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | V/ . | 10 | | | | 29c. LICE | | | | | | Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | | | EM 27 G | Poladi | | | | 0077 (| | | 16 2 | |
| | | | SE OF DEATH (IT | E-WI ∠ I) (N/D0, | rnnt) | | | | NAVAL | | | | TER |
| | NORMAN LEE LT N 31. DATE FILED (Month, Day, Year) | | R'S SIGNATUME | | | _ | BETH | ESDA | MD 20 |)889- | -5600 |) | |
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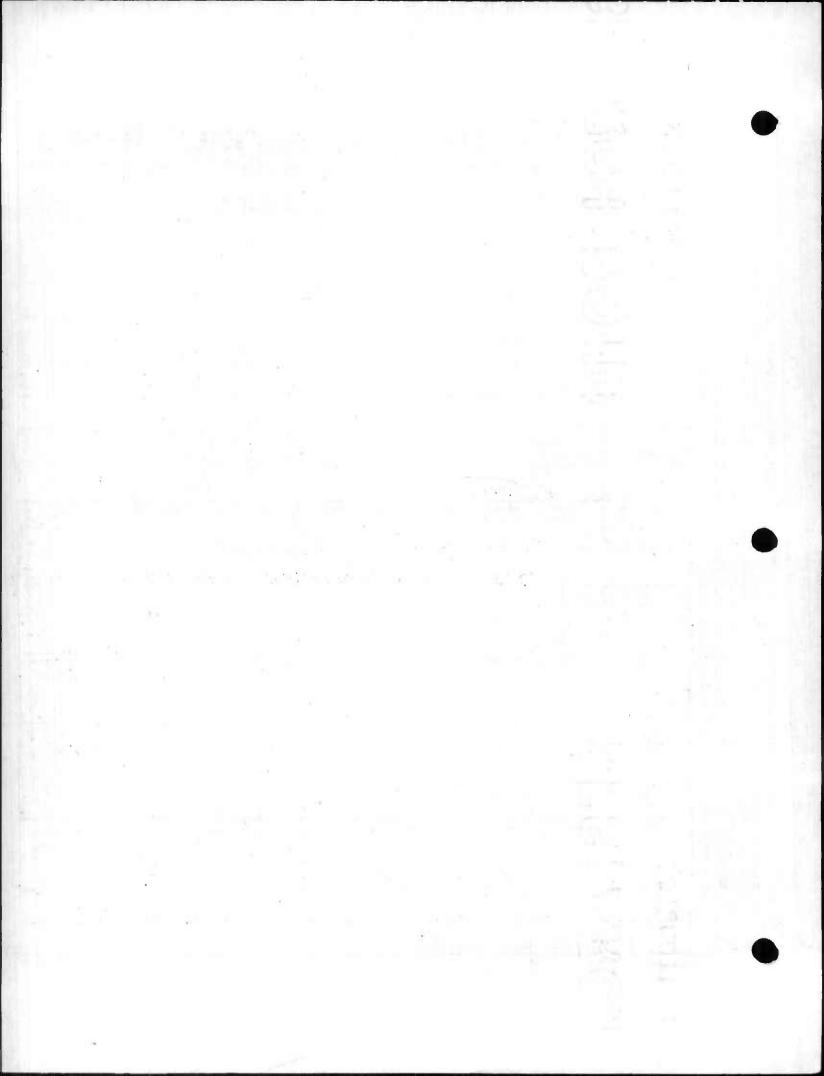


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DIVISION OF VITAL RECORDS, P.O. BOX 687

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should |
| be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal, |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| REGISTRAR | | CI | EKIIFI | CALE | OF DEATH | | REG. NO. | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------|---------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------|-----------------|---------------------------------|--------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Las | JE | ROM | A T | D | ALY | AUC | FUST 1 | 4 19 | YEAR | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER 096-12-2233 | 5. SEX 6 | L AGE (in yrs. les | t birthday) YRS. | MONTHS D | EAR IF UNDER 24 HRS. NYS HOURS MIN. | (Mont | OF BIRTH th, Day, Year) 7,19 | | Country | PLACE (State or Foreign) York | |
| 9a. FACILITY NAME (If not institution, give | a almost mad gumbart | | | AL OUT! | | | . /,13 | | | | |
| 9324 Garden Cour | | | | 96. CITY, TOWN OR LOCATION OF DEATH Potomac | | | | | 9c. COUNTY OF DEATH Montgomery | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| New York | m Nassau | | 10c, CITY | , TOWN OR L | ssapequa | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | |
| 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | 40- 047175 | | | |
| 8 Cambridge Driv | ve . | | | | 11758 | | | | | tates | |
| 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 X IF YES, GIVE WAN World Wa | R OR DATES | RMED NO | 13. WAS | DECENDENT OF HISP s, specify Cuban, Mexi YES 2 2 NO Spe | ANIC ORIGII icen, Puerlo cily: | N? (Specify Yes Rican, atc.) | or No— 1 | 4. RACE Black, Specify | - American Indian, White, atc. | |
| 15. DECEDENT'S EI (Specify only highest gra | | /G | CEDENT'S I | USUAL OCCU | PATION ng most of working | 168 | . KIND OF BUS | SINESS/INDU | STRY | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | | Dent | | | | Dei | ntal | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S I | NAME (Flort | | | | | |
| William E. | Daly | | | | A STATE OF THE PARTY OF THE PAR | | Conno. | | | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (S | reet end Number or Run | al Route Num | ber, City or Town | n, State, Zip C | code) | | |
| Jacqueline Daly | | | | | Drive, Ma | | | | | 11758 | |
| 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Re 4 Donation 5 Other (Specify) | emoval from State | cemetery, cre | AND DATE O | rer place i A | igust 21, nal Cemete | 1995 | Ca 13 | CATION — CH | | ew York | |
| 23. PART i. Entar the diseases, o shock, or heart felium iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST | DUE TO (O | O VISC OR AS A CONSE TENSION AS A CONSE OR AS A CONSE | OUENCE OF | R): CH | ACCIT RDIOVA | CU | | Dise | FAST2 | Approximata interval Between Onset and Das ACUTE | |
| | | | | | iying cause given | | PERFOR | MED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOCELES | | | | 6. PLACE OF DEATH | Check only o | ne) | | 1 | | |
| 1 PYES 2 NO | HOSPITAL: | ER/Outpatient 3 | DOA | OTHER: | Home 5 - Residence | 6 FOR | er (Specify) 1/ | KITKE | 10 | HOME | |
| 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF IN (Month, Day, | IJURY Year) | 26b. TIME | OF 28 | . INJURY AT WORK? | | SCRIBE HOW II | | | 11011/6 | |
| 2 Accident Investigation 3 Suicide 6 Could not b | 28a PLACE OF | INJURY — At he | ome, ferm, st | | YES 2 NO | 28f. LOC | CATION (Street a or Town, Stete) | and Number of | r Aural Ad | oute Number, | |
| 4 Homicide detarmined | | | | | | | == | | | | |
| (Check only | SICIAN: To the best of m | | | | | | | | | | |
| | | Oliner Leading | | | on, damin occurso at p | | | 0 002 10 1110 | cause(e) | end manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIF | Thuy | 11 | 14 | 9 | 29c, LICENSE N | | 9 | | | end manner as stated. (Month, Day, Year) | |
| | Thuy | OF DEATH (ITE | M 27) (7/pe, | 9 | 29c. LICENSE N | | 9 ETHE | | | | |



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARY | | TMENT OF | | MENTAL | HYGIEN REG. NO. | Ε | | | |
|--------------------|-----------------------------------------------------------------|---------------------------------------------|-----------------------------------|------------------------------------|--------------------------------|---------------|--------------------------------|------------------------------|----------------------|------------------------------------------------|--------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | OF OEATH | | | TIME OF DEA | TH |
| | Dorothy Ellis | | | | | MONTH | - 2 | | EAR | 945 | PH |
| | | 24 | (In yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE O | Day Yearl | | Country | VCE (State or F | |
| | 130 21 3032 | 1 □ M 2 🖾 F 6 | YRS. | | | Jun | e 16 | ,1930 | New | Jers | ey |
| œ | 9a. FACILITY NAME (If not institution, give stree | | | | OR LOCATION OF D | | | 9c. COUNTY | | | |
| Ō. | 5705 Legation C | Court | | New | Carroll | ton | | Prin | ce G | eorg | e's |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c, CIT | Y, TOWN OR LOCA | TION | | | | 100 | I. INSIDE CITY | , |
| | Maryland Princ | ce George | 's Ne | w Carr | ollton | | | | 10 | LIMITS? | NO |
| BY FUNERAL | 10e. STREET AND NUMBER | | | 10 | t. ZIP CODE | | | 10g. CITIZER | N OF WHA | COUNTRY? | |
| NEF | 5705 Legation (| | | | 20784 | | | | USA | | |
| F | 11. MARITAL STATUS 1 Never Married 2 Married | 2. WAS DECEDENT EVER FORCES? 1 YES | 2 🔼 NO | 13. WAS DE | CENDENT OF HISPA | NIC ORIGIN? | (Specify Yea | or No- 14 | . RACE — Black, W | American Indi | an, |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | 1 🗆 YE | 2 NO Specif | ly: | | | Specify: | Blac | k |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade cor | TION | 16a. DECEDENT'S | USUAL OCCUPATI | ON | 16b. I | KIND OF BUS | INESS/INDUS | TRY | | |
| LET | | College (1-4 or 5+) | life. Do NOT us | work done during m se retired.) | ost of working | | | | | | |
| MP | | 2 | Govern | ment C | lerk | | Gove | rnmen | t | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Mi | iddle, Maiden | Sumeme) | | | |
| 8 | Adolphus Ross 198. INFORMANT'S NAME (Type/Print) | | | | ZET | TER M | ARY C | ONEY | | | |
| 6 | Mark Ellis/Son | | 5705 T | ADDRESS (Street | Court, | Note Number | r. City or Town | n, State, Zip Co 1 + on - | MD | 20784 | |
| | 20a, METHOD OF DISPOSITION | 20 | b. PLACE AND DATE | | | DATE | 7 | CATION - CIN | | | |
| | 1 N Buriel 2 Cremation 3 Ramova 4 Donation 5 Other (Specify) | of from State | metery, cremetory or o Harmony | ther place) | al Par | 15 8/2E | Lar | dove | r . N | arvl: | hae |
| | 21. SIGNATURE OF FUNERAL BERVICE LICEN | see // /) | | 22, NAME A | ND ADDRESS OF FA | CHITY | | | | aryro | 211.0 |
| | I N TH awar | and B | avto | 1 7474 | B. Jenk Landove | ins . Road | tuner d. Lar | dover | ome MD | 2078 | 5 |
| | 23. PART I. Enter the diseases, or com | nplications that ceuse | d the teath. Do r | | | | | | | Approxim | |
| | shock, or heart fellure. Lis | t only one ceuse on | eech line. | | | | | | | Interval B | etween |
| | disease or condition resulting in death) | Large | CEIL L | unnlyn | 20 | | | | | | |
| - 1 | | DUE TO YOR AS | A CONSEQUENCE OF | 7 | | | | | | | |
| N O | Sequentially list conditions, b | anem. | A CONSEQUENCE OF | | | | | | | | |
| FA | If any, leading to immediate cause. Enter UNDERLYING | | | -): | | | | | | | |
| 읪 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF | 7); | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | |
| | PART II. Other significant conditions c | contribution to death i | but not moulting i | n the underlyle | n davina elvan la | Deed 1 | | | | | |
| PHYSICIAN: MEDICAL | | orning to docum | out not resulting i | n the underlyin | g cause given in | | PERFOR | MED? | AVA | RE AUTOPSY FI ILABLE PRIOR MPLETION OF (| TO |
| E | | | | | | _ | 1 YES 2 | X NO | OF | DEATH? | |
| 2 | DID TOBACCO USE CONTRIB | BUTE TO CAUSE O | OF DEATH YE | S FI NO F | UNCERTAI | N 154 | | | 1 | YES 2 | NO |
| XX. | 25. WAS CASE REFERRED TO MEDICAL | | 28. PLACE OF DEAT | | OTTOLKIAN | 1 50 | | | | | |
| SIC | EXAMINER? 1 YES 2 NO | OSPITAL: ARAM | petient 3 DOA | OTHER: | e 5 Residence | 6 🗆 Other | (Specify) | | | | |
| E | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 266. TIM | | | | | JURY OCCUR | ED | | |
| ΒY | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 | rES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be | 28a. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, a | treet, fectory, offic | | | TON (Street as Town, State) | nd Number or I | Rural Route | Number, | |
| COMPLETED | | | | | | | | | | | |
| AP. | | N: To the best of my know | | | | | | | | | |
| 8 | Z MEDICAL EXAMINER: C | On the basis of examination | on and/or investigation | n, in my opinion, o | eath occured at the | time, date a | nd place, and | due to the ca | suse(s) and | ! manner sa s | lated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Λ ο. | | | 29c. LICENSE NUI | MBER | | 29d. DATE SI | GNED (Mo | nth, Day, Year) | |
| 6 | 30. NAME AND ADDRESS OF DESPOSAL WAYS | | SICION | Defeat | D418 | 5 | | P 81. | 23/ | 95 | |
| | ALLANS ROLLING | OMPLETED CAUSE OF DE | | | · am r | - | | | 2 | | |
| ľ | 31. DATE FILED (Month, Day, Year) | 32. BEGISTRAR'S SIGN | VATURE | INC DE | = 900 S.1 | VEN | A FOR | MA | 209 | 10 | |
| - 1 | AUG 23 1995 | Talia Drivale | | | | | | | | | |



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| IIVISION OF VITAL RECORDS, P.O. BOX 6876 | OR ATTENDING PHYSICIAN: The law remires that the death certificate be executed w |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | OB ATTENDING PHYSICIAN: The law remaines that the death certificate be executed with cours after death. Page 6 may be retained by the bosonics or amendion obtains |

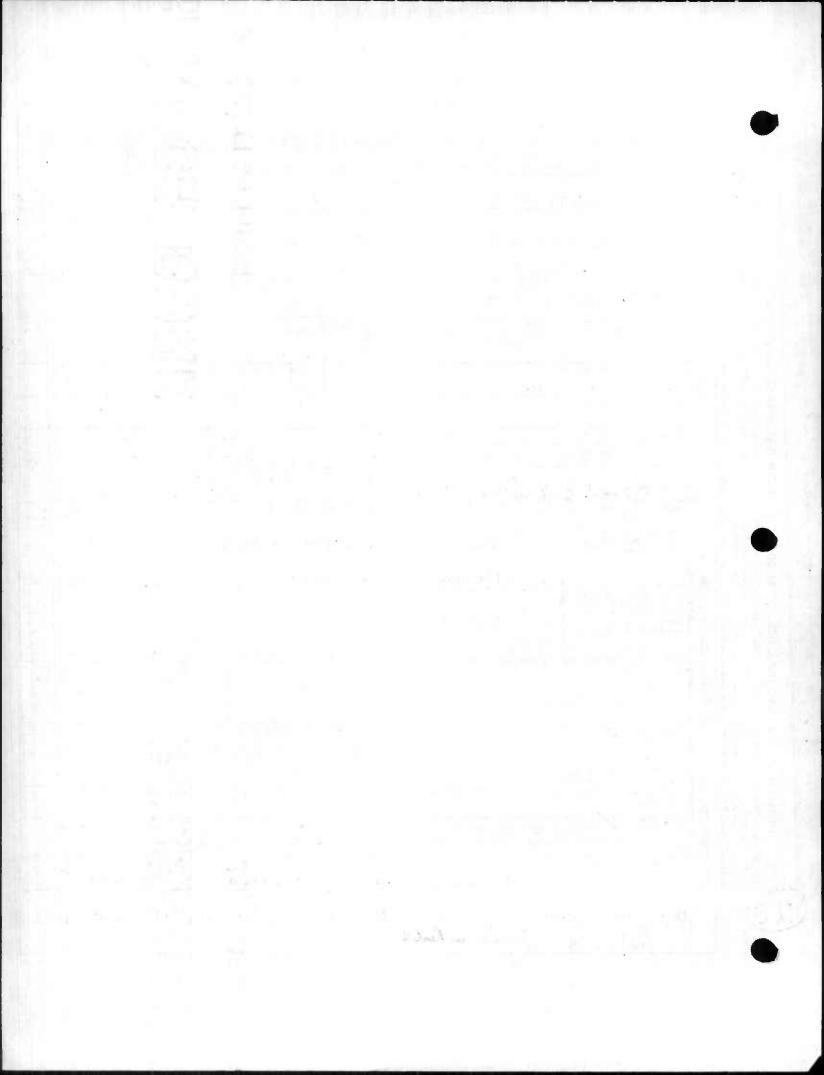
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAN | | | OL. | -11111 | ICATE | - 01 | DEA | 111 | | HEG. NO | | | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------|----------------------|-------------|-------------|-----------------------|---------------------|-------------------------------------------|-------------------------|---------------------------------|-------------------------------|---------------------|--------------------------------------|--|
| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE | OF DEATH | AY | YEAR | 3. TIME OF DEATH | |
| | Jane Ali | | Erb | | | | | | | Augi | | | 95 | 2:30 P M | |
| | 4. SOCIAL SECURITY NUMBER | R | 5. SEX | 6. AGE (In yrs. lest | birthday) | IF UNDER | | IF UNDER | | | OF BIRTH | | O. BIRTH | IPLACE (State or Foreign | |
| | 217-44-7032 | 217-44-7032 1 D M 2 1 F 50 YRS. MONTHS DAYS | | | | | HOURS | MIN. | (Month, Day, Year) Country) 12-25-44 Ohio | | | | | | |
| | 9a. FACILITY NAME (If not ins | titution, give i | street end number) | 30 | | 9b. CITY | , TOWN | OR LOCATI | ON OF DI | | 23 44 | 9c. COU | 9c. COUNTY OF DEATH | | |
| æ | 15107 Paragr | ino (| 7+ | | | | D. | | | | | | | | |
| DIRECTOR | 15107 Peregr | THE C | ٠. | | _ | | ВС | wie | | | | Prince Georges | | | |
| ĕ | | 10b. COUNT | | | 10c. CIT | Y, TOWN C | OR LOCAT | TION | | | | | | 10d. INSIDE CITY | |
| G | Marvland | Prin | ce Georg | 96 | | В | owie | | | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | | | | | | | ZIP COD | F | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 15107 P | | | | | | | | | TIAL COOKING | | | | | |
| N. | 11. MARITAL STATUS | ine C | | IT EVER IN U.S. ARI | | 1 | | 2072 | | | | US | | | |
| 교 | 1 Never Merried 2 R | Aerried | FORCES? 1 | YES 2 N | MED | 13. | WAS DEC If yes, sp | ecify Cube | of HISPAI on, Mexica | NIC ORIGI an, Puerto | N? (Specify Yes Rican, etc.) | s or No— | 14, RACE Black | - American Indian, k, White, etc. | |
| B | 3 Widowed 4 Divorce | ced | IF YES, GIVE V | MAR OR DATES | | | YES | 2 🔯 NO | Specif | ly: | | TY3 | Speci | | |
| ED | 15 DECE | DENT'S EDU | CATION | Ten DE | CEDENTIO | 1101111 | 00110174 | | - | 1 | | | | White | |
| E | (Specify only | highest grade | | (G/ | ve kind of | work done | during mo | on ist of workli | ng | 16 | b. KIND OF BU | SINESS/INC | JUSTRY | | |
| 빌 | Elementary/Secondary (0-1 | 12) | College (1-4 or 5 | +) | | | | - | | | | 1.10 | | | |
| M | 12 | | 4 | Inio | rmat | 10n | Mgt. | | | | U.S. | | ernm | ent | |
| COMPLET | 17. FATHER'S NAME (First, Mic | | | | | | | 18. MOT | HER'S NA | ME (First, | Middle, Melden | Surname) | | | |
| BE | | | lorrison | | | | | Bar | bara | a I | Ellen | Ke1 | ty | | |
| 10 | 19e. INFORMANT'S NAME (Ty) | oe/Print) | | 196 | . MAILING | ADDRESS | S (Street a | and Number | or Aural | Route Nun | nber, City or Tow | m, Stete, Zip | Code) | | |
| = | Joseph P. | Er | ъ | 15 | 107 | Pere | grin | e Ct | . Bo | owie. | Mary | Land | 2072 | 1 | |
| | 20e. METHOD OF DISPOSITIO | | | 20b. PLACEA | ND DATE | OF DISPOS | ITION /N/ | me of | | OA. | TE 20c. LO | CATION - | City or To | own State | |
| | 1 😾 Buriel 2 🗆 Cremetion 4 🗎 Donation 5 🗆 Other (| | ioval from State | St - R | metory or o | ther place) | eme | terv | 8- | 24-9 | 5 Jinne | r Ma | rlho | ro Maryland | |
| | 1 No Burlel 2 Cremetion 3 Removal from State Cemetery, Cremetory or qiher place St. Barnabas Cemetery 8-24-95 Upper Marlboro, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Funeral Home, P.A. | | | | | | | | | | | io, marytano | | | |
| | 20.4 | 10 | | 0 | | Ro | bert | E. | Evar | is Fu | ineral | Home | , P. | Α. | |
| | Kobert E. Evans, Pres. 16000 Annapolis Road Bowie, Md. 20715 | | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. | | | | | | | | | | | | | | |
| | anock, or heart fellure. List only one cause on each line. | | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fine) disease or condition Small Cell CARCINOMA (IDNEY) | | | | | | | | | | b Cl | | | | |
| | reaulting in death) | • | | OR AS A CONSEC | | | .1100 | I II PL | 101 | DIAC | 1 | | | lyr mos. | |
| | | | 1 | | - | 2 | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | | | | | | |
| F | If any, leading to immed cause. Enter UNDERLYIN | late | 502 10 | (OR AS A CONSEC | OENCE O | ·): | | | | | | | | | |
| 일 | CAUSE (Disease or Injur | y < | C. DUE TO | (OR AS A CONSEC | HENOE O | - | | | | | | | | | |
| Ē | that initiated eventa resulting in death) LAST | | 506 10 | (OH AS A CONSEC | DENCE O | r): | | | | | | | | | |
| E | | | d | | | | | | | | | | | | |
| | PART II. Other significan | t condition | ns contributing to | daeth but not re | esulting | in the ur | derivin | n ceuse : | niven in | Part I | 24a. WAS AN | ALITOPSY/ | 240 | . WERE AUTOPSY FINDINGS | |
| EDICAL | | | | | | | | | 9. 4 011 111 | | PERFO | | 2.40 | AMAILABLE PRIOR TO | |
| ă | | | | | _ | | | | | | 1 TYES 2 | NO | | OF DEATH? | |
| Z | | | | | | | | | | | | | | 1 TES 2 NO | |
| ä | | | | | | | | | | | | | 5 00 | | |
| SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | | | | | | ACE OF D | EATH (Ch | neck only a | ne) | | | | |
| SIC | 1 YES 2 NO | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER | | n 5 17 R | sidence | B C Oth | er (Specify) | - | | | |
| РНҮ | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 28b. TIN | E OF | 28c. INJ | URY AT | | _ | SCRIBE HOW I | NJURY OC | CURED | | |
| | 1 Natural 5 P | ending | (Month, E | Day, Year) | IN. | JURY | | PRK? | □ NO | | | | | | |
| ВУ | a Contact | rvestigation | 28e, PLACE C | OF INJURY — A1 hor | me form | street fact | | _ | | 284 1 0 | CATION (Street | and Mumba | a or Print I | South Alumbus | |
| 8 | | could not be etermined | building, | etc. (Specify) | | | ory, orne | | | C/ty | or Town, State) | ena rvarnosi | or nurer r | todie Number, | |
| COMPLET | 29e, CERTIFIER | | | | | _ | | | | | | | | | |
| 집 | (Check only | | ICIAN: To the best of | | | | | | | | | | | | |
| ON | one) 2 MEDIC | AL EXAMINE | ER: On the basic of e | examination end/or i | nveatigatio | on, in my o | pinion, d | leath occu | red at the | time, det | e end place, er | d due to th | ne cause(4 | e) and menner ee stated. | |
| EC | 29b. SIGNATURE AND TITLE | OF CERTIFIE | R | | | | | 29c. LIC | ENSE NUI | MBER | | 29d DAT | F SIGNED | (Month, Day, Year) | |
| 8 | () | 0 | m. | | m | D | - 1 | D | 111 | 115 | • | N | 2/21 | 4 | |
| 5 | 30. NAME AND ADDRESS OF | PERSON WA | O COMPLETED CALL | SE OF DEATH STEE | | | | ن | 1 | 167 | | | 7/01 | 110 | |
| | Man of Man | - DA | D OPP | O LEAN (ITEM | | | 0 | - | ~ ^ | | . 1 . | 00- | | | |
| | THIN C. 11) STO | 4, 111 | .U. 700 | 120AL25 | te | Rd, | 2014 | e 3 | D, F | 1415 | (Y)(1) | MI |) 7 | 21901 | |
| | 31. DATE FILED (Month, Day, N | | 32. REGISTRA | AR'S SIGNATIVE | 2.11 | , | | | - | | | | | | |
| | AUG 25 | כבבו | Java wa | Contract a state | | | | | | | | | | | |
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permit. Pages 1, 2, 3 should

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To

notified

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reflail | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sh | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notif |
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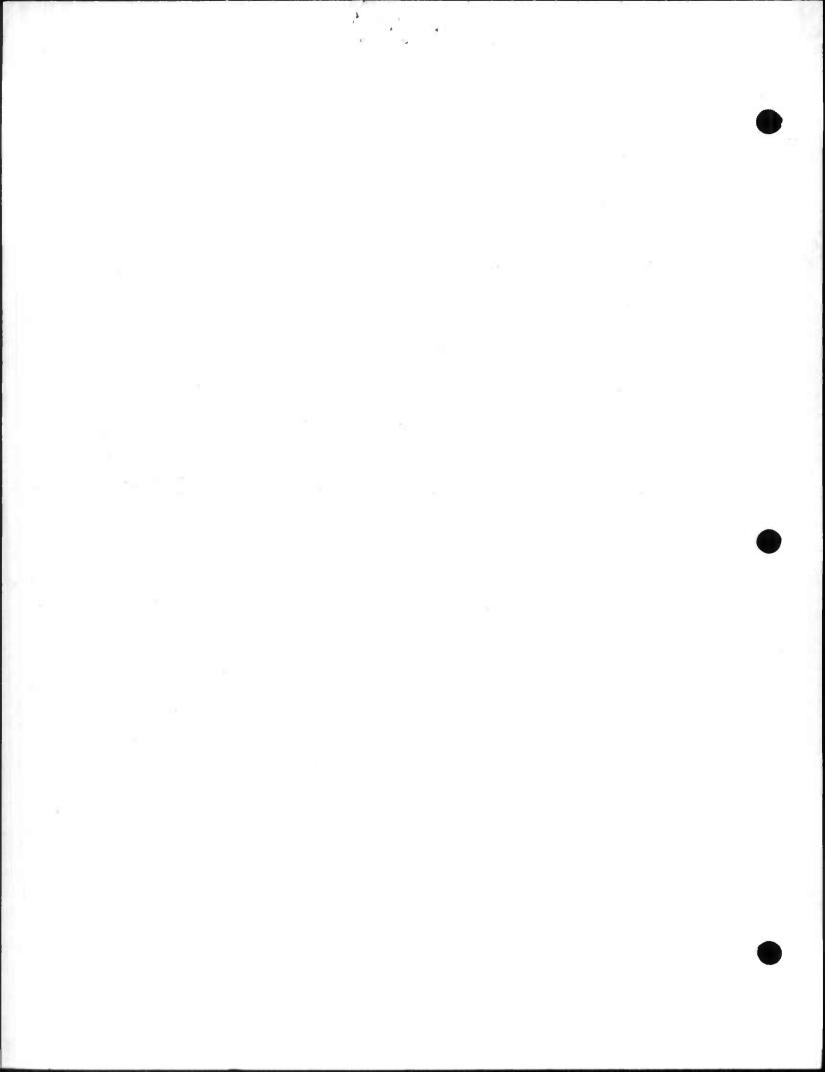
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH **EUSANTOS** ALPHONSO Reboja AUGUST 1995 11:10 P M 4. SOCIAL SECURITY NUMBER July 27,1956 IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. AGE (In yrs. last birthday) BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS MIN 216-70-8139 1 X M 2 - F Maryland 9e. FACILITY NAME (If not Institution, give street end number)
12200 CEDARVILLE ROAD 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PRINCE GEORGE Brandywine DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Brandywine 1 VES 2X NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 16330 Baden Westwood Road 20613 U.S.A. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried Specify. BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 12th Mechanic Tommy's Auto Center 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Dario R. Eusantos Penelope Fay Coyne BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 9-F Marcs Ct. Annapolis, Md 21403

20b. PLACE AND DATE OF DISPOSITION (Name of Aug. 30 pdf 99 520c. LOCATION - City or Town, State Regina Eusantos 20s METHOD OF DISPOSITION
1 | Disputel 2 | Cremation 3 | Removal from State Mary Land State Veterans Cem. Cheltenham, Maryland 4 Donetion 8 Other (Specify) 21. SIGNATURE OF FYNERAL SERVICE LIPENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23. PART I. Enter the diseases, or Approximata **Onest and Death** IMMEDIATE CAUSE (Final disease or condition Stiple injuries resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequantistly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reautting in death) LAST PART ii. Other significent conditions contributing to dasth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 NO 1 EX YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER TX YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home 5 - Residence ex Other (Specify) 2200 CEDARVILLE RI 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Neer) 28b. TIME OF INJURY 2155 M 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? 1 Netural 5 Pending 8/25/45 1 YES 2 NO DRIVER, LOST CONTROL OF TRUCK BY 2X Accident Investigation 281, LOCATION (Street eng Number or Rural Route Number, City or Town, State) PRINCE GEORGES COUNTY MD 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide COMPLETED 6 Could not be determined 4 Homicide ROAD WAY 12200 BLOCK CEDERVILLE RD 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner ee atated. 2 X MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 1996. SIGNATURE AND TITLE OF CENTERER WRIGHT MD 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE AUGUST 26 1995 .C.M.E. 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 DUNALD G. WRIGHT MD 31. DATE FILED (Month, Day, Year) 1995 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall

Amended Line 4 - Harford County 8-28-95 23152

| | 1 - STATE REGISTRAR | | STATE OF I | MARYL | | | | | DEAT | | MENTA | L HYGIEN REG. NO | E | | | |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------|----------------------------------------|-------------------|-----------|-------------|------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------|----------------------------------------|---------------------|--------------|---------------------|-----------------------|-------------|
| | 1. DECEDENT'S NAME (FIR | A. | | | | EG | AN | | | | MONT | OF DEATH DO | | YEAR 95 | 3. TIME OF DI 9:36 | P M |
| | 4. SOCIAL SECURITY NUM | 2471 | 5. SEX | 6. AGE (in yrs. last birthday) IF UNDE | | | IF UNDER | 1 YEAR DAYS | | | 7. DATE OF BIRTH (Month, Day, Year) | | | 8. BIRTI- Counti | IPLACE (State or | Foreign |
| BY FUNERAL DIRECTOR | 228-80-25 | | | | 34 | YRS. | 9b. CITY | TOWN | OR LOCATIO | ON OF DE | | e 13,1 | _ | New | York | |
| | THE JOHNS HOPKINS HOSPITAL BALT: | | | | | | | LTIM | ORE (| CITY | | | | | | |
| | 10a. STATE 10b. COUNTY | | | | | 10c. CIT | Y, TOWN | R LOCAT | TION | | | | 10d. INSIDI | | 10d. INSIDE C | ity |
| | Maryland 100. STREET AND NUMBER | | Harford | d Edgewood | | | - | 10f. ZIP CODE | | | | | | 1 X YES 2 | | |
| | 927 Angel | | | | | | | 040 | | | | S.A. | WHAT COUNTRY | 7 | | |
| | 1 Never Married 2 Married FORCES? | | | | TES 2 JNO If yes | | | | DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- 14. RACE - A | | | | ndlen, | | | |
| ובח | | CEDENT'S EDU ily highest grade | | | (Give | kind of | USUAL O | CUPATIO | | | | | | | | |
| BE COMPLET | Elementary/Secondary (0-12) College (1-4 or 5- | | | | +) Systems Engine | | | | eer Mortgage Corporat | | | ation | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | 18. MOTHER'S NAME (First, Middle, Melden Surneme) | | | | | | |
| | John F. Egan 190. INFORMANT'S NAME (Type/Print) | | | | 19b. 8 | AAILING | AODRESS | (Street e | | | | blasi | o State 7/ | Code) | | |
| 2 | Mrs. Caro | LA. Ec | ran | | | | | | | | | | | | nd 2104 | 0 |
| | 20e. METHOD OF DISPOSI 1 Burlai 2 Cremati | on 3 🗆 Rem | oval from State | cen | b. PLACE ANI | tory or o | ther place) | | | | DAT O / | | | City or To | | 1 |
| | Harford Memorial Gardens 8/25 Aberdeen, 11. SIGNATURE OF FUNERAL/SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | l | | | | |
| | Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dyhaert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (or as a consequence of): List only one cause on each line. Due To (or as a consequence of): List only one cause on each line. Due To (or as a consequence of): List only one cause on each line. Due To (or as a consequence of): | | | | | | | | | | Between nd Death | | | | | |
| IAN: MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underly Real Failure, Adynamic Ileux | | | | | | | derlying | PERFORMED? 1 YES 2 NO COMPLETION OF OF GEATH 1 YES | | | | OT NO | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF THE STATE OF DEATH CORES AND ORGEN | | | | | | | | | | | | | | | |
| 25 | 1 YES 2 NO | ESSENSIVE S | NOSPITAL: | ER/Outp | petient: 3 🗆 | DOA | OTHER | | s S □ Rei | sidence | 6 🗆 Othe | r (Specify) | | - | | |
| ETED BY PHYSIC | 23 MANNER OF DEATH 1 Return 5 Pending (Month, Clay, Year) 2 Accident Investigation | | | | | | 1 U y | E. HJURY AT WORKY 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | |
| | 3 Suicide 6 Could not be determined 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE DF INJURY — At home, farm, street, factory, office City or Town, Stete) | | | | | | | | | | | | | | | |
| | | | CIAN: To the best of | | | | | | | | | | | | | |
| COMP | Nec | - | R: On the basis of a | kaminatio | n end/or Inve | atigatio | n, in my o | olnlon, d | eath occur | ed at the t | time, data | and place, and | due to th | ie cause(s) |) end manner es | stated. |
| IO BE | 296. SIGNATURE AND TITLE OF CENTRULIN | | | | | | | 29c. LICENSE NUMBER N 2624 29d. DATE SIGNED (Morrith, Day, Year) August 21 189. | | | | | | | | |
| | Beijanin H | , Tr. c | COMPLETEO CAUS | SE OF OE | | 7) (Type, | - | Joh. | ns t | toph | ins | Hosp | sita | ١ | | |
| | AUG2 3 | 1995 | Ja Megastra | A'S SIGN | PARAL | | | | | | | | | - | | |
| ! | AUG2 8 1995 | Jalia | Dhudson | Carola | Ц | | | | | | | | | | DHMH | 18 Rev 1/80 |
| | A D I | | on Autom Tan g (A. | 300 F 360 | 4.1 | | | | | | | | | | | |



LTIMORE, MARYLAND 21215-0020

FOR

| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------|-----------------------------|----------------------------------------|--------------|-------------------|---------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | = 10. | - | | 2. DATE OF DEATH MONTH D | | | 3. TIME OF DEATH | | | |
| | JOHN | NEWTON | | | FARA | BEF | | AUGUST 18 | | 995 | 6:25 Am | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | | IF UNDER 1 YEAR | - | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | ATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | |
| | 287-22-6912 | Λ | ¹ X ^{M 2} □ F 64 | | | | | 11-02-30 | | | nsylvania | | |
| ~ | 9e. FACILITY NAME (If not institution, give | | | 9b. CITY, TOWN | OR LOCATI | ON OF DEA | TH | 9c. COU | NTY OF DE | EATH | | | |
| 힏 | 12412 Rockledge Drive Bowie Prince GEORGE'S | | | | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | 10d. INSIDE CITY | | | |
| | Maryland Prin | es | | Bowie | | | | LIMITS? | | | | | |
| AL | 10e. STREET AND NUMBER | | | | | of. ZIP COD | E | | 10g. CITI | ZEN OF W | HAT COUNTRY? | | |
| FUNERAL | 12412 Rockledge I | | | | | | | USA | | | | | |
| 5 | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. ARA | MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | | | or No- | 14. RACE Black | - American Indian, White, etc. | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE W | | lict | 1 🗆 YI | 1 ☐ YES 2 🔯 NO Specify: | | | Spe | | | | |
| | 15. DECEDENT'S EDI | UCATION | 16a, DEC | EDENT'S | USUAL OCCUPAT | TION | | 18b. KIND OF BUS | SINESS/IND | HISTRY | white | | |
| E | (Specify only highest grad Elementary/Secondary (0-12) | (e completed) College (1-4 or 5 - | (GA | w kind of a | work done during i se retired.) | nost of working | ng | | | | | | |
| P. | 12 | 2 | | Mana | ger | | | Self | Emp. | loyed | i | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTI | HER'S NAM | E (First, Middle, Maiden | Surname) | | | | |
| BE | John Leonard Far | abee | | | | | | Theo Mun | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | 1 | | | | | ute Number, City or Tow | | | | | |
| | Sheila Farabee | | | | | | rive | Bowie, Ma | | | | | |
| | 1 Buriel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) | noval from State | cometent oran | | of Disposition (| | Q_ 2 | 5-95 Che | | , | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | - Ind. ve | tera | | AND ADDRE | | | rtenn | ialli, | Maryland | | |
| | + Robert E. 8 | | 0 | | | | | Funeral | | | | | |
| | | | PJ\US | th Do | 16000 | Anna | polis | Road Bow | ie, N | lary] | | | |
| | snock, or heart fallure. | List only one cau | se on each lina. | in. Do I | iot entar the n | ioda oi dyi | ing, such | aa cardiac or reapi | ratory arr | est, | Approximate Interval Between | | |
| | 3. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. MMEDIATE CAUSE (Final listense or condition. | | | Onset and Death | | | | | | | | | |
| | resulting in death) a. MYCARDIAL INFARCTION DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | minutes | | |
| Z | ATHEROSCLETICTIC CARDIDVASCULAR DISPASE | | | | | | | | | | | | |
| CERTIFICATION | Sequentially late conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 5 | CAUSE (Disease or injury | c HYPETO | 278NS1 | ON | | | | | | | yes, | | |
| | that initiated events resulting in death) LAST | 7 002 10 | (ON AS A CONSECU | JENCE U | r): | | | | | | , | | |
| S | | d | | | | | | | | | | | |
| DICAL | PART II. Other algorificant condition | | | | | ng cause g | given in P | art I. 24e. WAS AN | | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | |
| 8 | GLIOBLASTON | IA MULTI | FORME, F | SPAL | N | | | 1 _ YES 2 | M NO | 1 | COMPLETION OF CAUSE OF DEATH? | | |
| ME | | | | | | | | | | | 1 _ YE\$ 2 _ NO | | |
| PHYSICIAN: | DID TOBACCO USE CONT | RIBUTE TO CA | | | | | ERTAIN | | | | | | |
| S | EXAMINER? | HOSPITAL: | | | OTHER: | | | | | | | | |
| ¥ | 27. MANNER OF DEATH | 28e. DATE OF | ER/Outpatient 3 [| 28b. TIM | | me 5 Re | | Other (Specify) | N II IOV OCC | TIBED | | | |
| | 1 Natural 5 Pending | (Month, Di | ay, Year) | | URY | YES 2 | 10.0 | LOG. DESCRIBE NOW II | WONT OCC | UNED | | | |
| D BY | 3 Suicide 6 Could not be | 28s. PLACE Of | F INJURY — At home | e, ferm, s | Breet, factory, off | Ice | | 281. LOCATION (Street a | nd Number | or Rural Ro | oute Number, | | |
| | 4 Homicide datermined | conony, | ett. (Specify) | | | | | City or Town, State) | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the Ilme, date end place, end due to the cause(e) and manner se stated. | | | | | | | | | | | | |
| one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the | | | | | | | | | | cause(s) | and manner as stated. | | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | Я | | | | 29c. LICE | NSE NUMB | ER | 29d. DATE | SIGNED (| Month, Day, Year) | | |
| TO B | Stryel MD | | | | | D2 | 59 | 25 | ► au | yunt | 1871995 | | |
| | 30. NAME AND AGORIES OF PERSON WI | O COMPLETED CAUS | SE OF DEATH (ITEM | 27) (Туре, | Print) | 4 | 0 7 | 7 0 | | 4 | | | |
| | BEYEL MD 30. NAME AND ADDRIES OF PERSON WIT J. BERGER MD # 31. DATE FILED (MOOTH). Day, Year) | 1205, 1 | 120 W | 1500 | NSIN / | we, | Bel | Kesda, K | Mol | 208 | 74 | | |
| | AUG 25 1995 | 32 AEGISTRA | R'S SIGNATURE | LIL | | | | | | | | | |

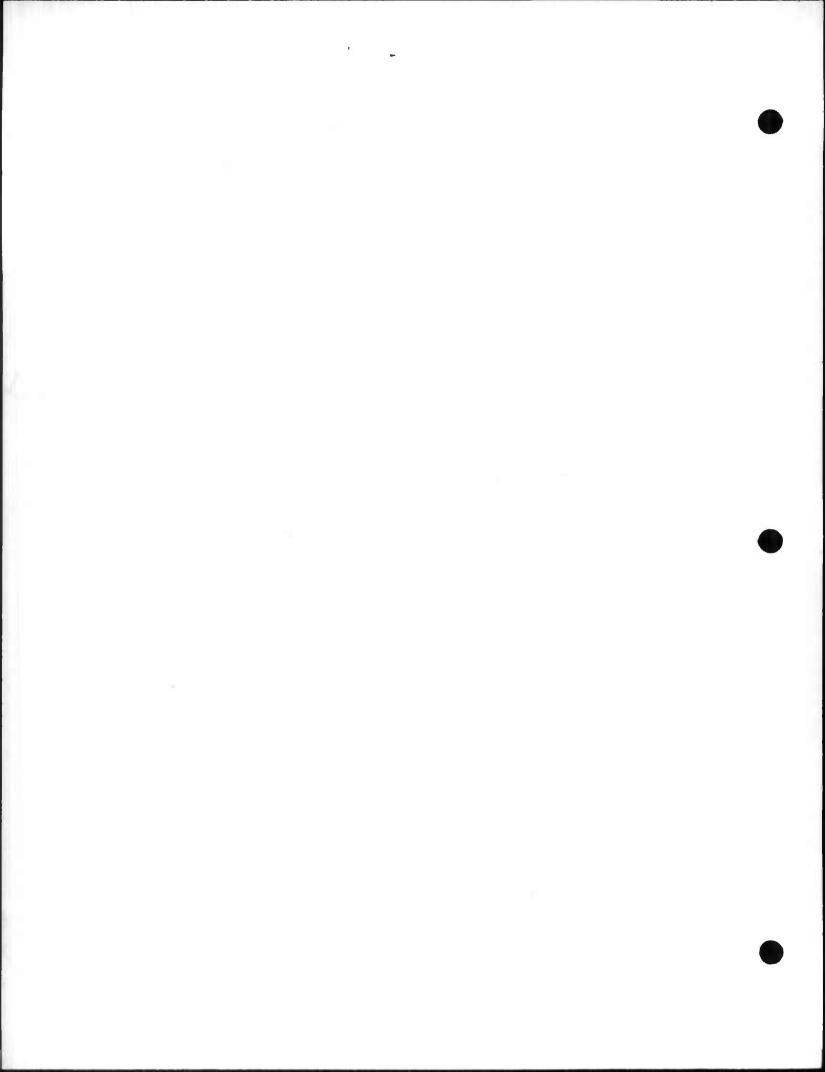
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | | HEGISTRAR | | | ENITE | JAIL | OF DEATH | REG. NO | | | |
|------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------|-------------------------|----------------|------------------------------------------------|----------------------------------------|----------------------------------------------------|-----------------------------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | * " | 2. DATE OF DEATH | AYOF YE | 3. TIME OF DEATH | |
| | | | rances | | | ITZGERA | LD | AUGUST 24,1995 | | 12:14AM | |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | | FUNDER (YEA | | 7. DATE OF BIRTH (Month, Day, Year) | 8. 9 | BIRTHPLACE (State or Foreign Country) | |
| P | | 578-24-2252 | 1 🗆 M 2 🙀 F | 80 | YRS. | | | | 1915 W | Vashington DC | |
| 3 should | ~ | 9e. FACILITY NAME (If not institution, give | | | | | WN OR LOCATION OF DE | ATH | 9c. COUNTY | OF DEATH | |
| ci. | ē | PHYSICIANS MEMORIAL I | | LAPLAT | .'A | | CHARLES | | | | |
| es 1 | E C | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | 10d. INSIDE CITY | |
| 2 | FUNERAL DIRECTOR | Maryland Ch | arles | | N | aldor | f | | LIMITS? | | |
| Sermi | | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| burial-transit permit. Pages | | 5934 Michael Road | đ | | | - 1 | 2060 | 1 | US | Ä | |
| ial-tra | | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. | RMED | 13. WAS | DECENDENT OF HISPAN | IC ORIGIN? (Specify Yes | or No.— 14. | RACE — American Indian, Black, White, etc. | |
| po por | ВУ Б | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE W | YES 2 X | INO | | i, specify Cuban, Mexica YES 2 D NO Specify | | 1 1 | Black, White, etc. Specify: | |
| as the | | | 1 | | | | Α | | | White | |
| use | ETEI | 15. DECEDENT'S EDI (Specify only highest grad | | | Give kind of wo | rk done during | PATION g most of working | 16b. KIND OF BUS | SINESS/INDUST | RY | |
| d for | | Elementary/Secondary (0-12) | College (1-4 or 5 | , | le. Do NOT use | | | | | | |
| detached once. | COMP | 10 17. FATHER'S NAME (First, Middle, Last) | | Phy | sical | Educa | tion Teach | | | | |
| at o | | Francis Falstreau | | | | | 74.20 72.50 | ME (First, Middle, Maiden | Sumame) | | |
| bed : | 8 | 19e. INFORMANT'S NAME (Type/Print) | 1 | Τ, | ION MAILING A | DDDESS (Co. | Mary E. | | | | |
| 5 should notified | 임 | Rita M. Tewell | | 1 | | | | | | (a) | |
| page page | | 20a. METHOD OF DISPOSITION | | 20h PLAC | 5 1 U.3 EAND DATE OF | | d Drive, W | | 20601 CATION — City | | |
| completely filled in by the funeral director, part, cremation, or removal. c event, the medical examiner must | | Buriel 2 Ofemation 3 Rer | noval from State | cametery, c | remetory or other | r placel | | | | | |
| al dir | | A Donation s/t Other (Specify) Reusriection Cemetery 8-28 Clinton, MD 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| tuneral di I. examiner | | * your A | Locat | our | - | Hun | tt Funeral | Home, Inc | | | |
| the noval. | $\vdash\vdash$ | Mrk G. Brohawn M00053 P. O. Box 156 Waldorf MD 20604 0156 | | | | | | | | | |
| or remova medical | | 23. PART I. enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | |
| tion, c | | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | |
| ompletely il, cremat event, i | | resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| fal. c | _ | _ | 502 10 | (OH AS A CONS | EUOBNICE OF): | | | | | | |
| the attending physician and completely fille Mental Hygiene prior to burial, cremation, njury, or other traumatic event, the | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | |
| Siciar prior trau | CAT | | | | | | | | | | |
| ing phy giene p | Ē | that initiated events | DUE TO | OR AS A CONS | EQUENCE OF): | | | | | | |
| Hyg or o | 12. | resulting in death) LAST | | | | | | | | | |
| y the att | - 1 | PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | |
| signed by the Health and I | EDICAL | <u> </u> | resulting in | the underi | ying cause given in | PERFOR | | AVAILABLE PRIOR TO | | | |
| signed fealth | | | | | | | 1 YES 2 | K No | COMPLETION OF CAUSE OF DEATH? | | |
| of F | Σ | DID TOPACCO LISE CONTRIBUTE TO CALICE OF PEATH WAS TO AN OFFICE AND THE WASTE OF THE PEACH OF TH | | | | | | | | | |
| Dept. | SICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| this certificate has been with the State Dept. of rked, or Item 23 sho | | EXAMINER? | HOSPITAL: | | | THER: | and a massing | A ISOSTAN | | | |
| certific the | Ì Ì | 27. MANNER OF DEATH | 28e. DATE OF | | 285. TIME (| | INJURY AT | 28d. DEŞCRIBE HOW II | ILIBY OCCUPE | in . | |
| ter this sath with | A . | 1 Netural 5 Pending | (Month, D. | ny, Year) | INJUE | Y | WORK? | | | | |
| death | D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE O | F INJURY - At h | nome, farm, stre | | | 28f. LOCATION (Street e | LOCATION (Street and Number or Rural Route Number, | | |
| after 28 | Ш | 4 Homicide determined | building, | etc. (Specify) | | | | City or Town, State) | | 200 | |
| DIRE | PLET | 290. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the heat of | my knowledge o | feeth nearwood | et the time | date and place, end due | | i i pe lumber. | | |
| RAL | 2 | | | | | | | | | use(s) end manner as stated. | |
| THE FUNERAL DIRECTOR: After filed within 72 hours after death PORTANT: If Item 28 is man | 8 | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | | | | | |
| Pog ged | 8 | Milli | 701.1 | test i | ma | | 29c. LICENSE NUM | BER | 29d. DATE SIG | NED (Month, Day, Year) | |
| 2 € 3 | 2 | 30. NAME AND ADDRESS OF PERSON WI | 10 COMPLETED CAUS | E OF DEATH (IT | EM 27) (Type: Pi | int) | D-21031 | | 8/ | 27/9) | |
| | | MICHAEL LEATHERWOOD M | | | | | X 2/19 LIAT TOT | F MD. 20604 | | | |
| | | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | AUG 2 9 1995 | Talin d | Audion A | Cardall. | | | | | | |
| L | | | 1) | - | A-A | | | | | | |

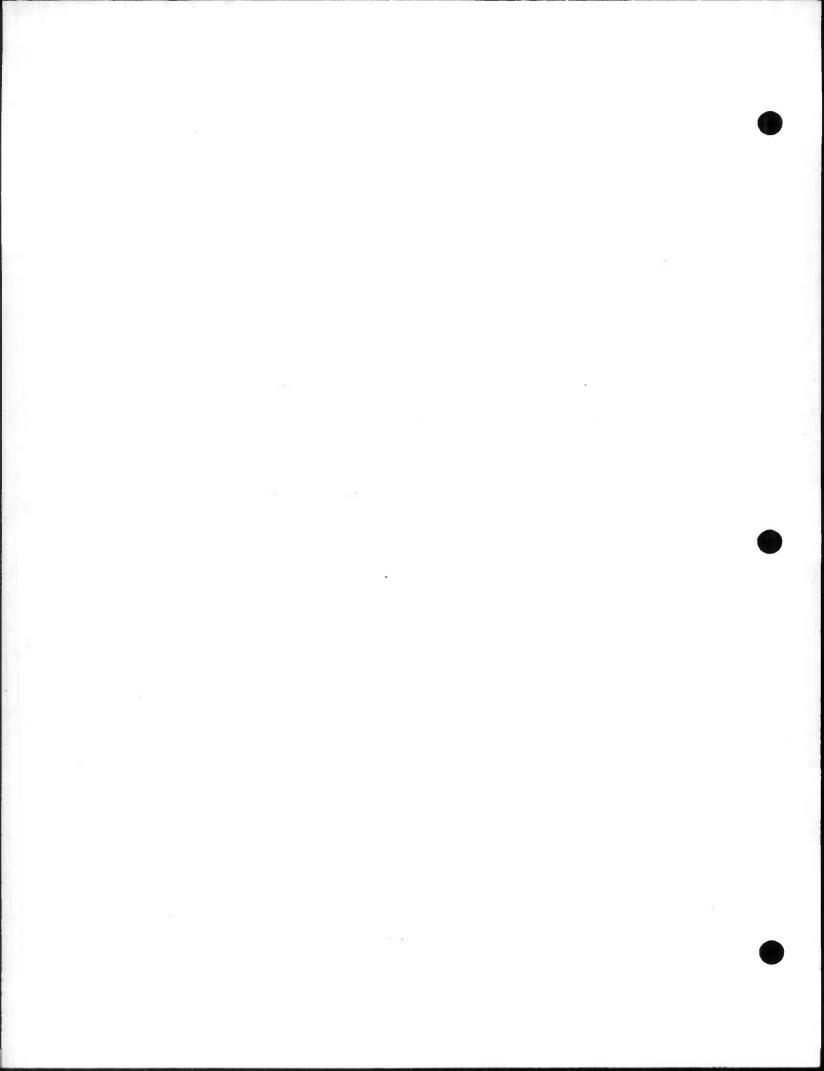


27055 95

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. N | Ю. | | |
|---------------|------------------------------------------------------------|--------------------------------|------------------------------------|--------------------------------|----------------------|-----------------------------------------------|-----------------------------------------|------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH | 044 | 3. TIME OF DEATH | |
| | Herbert Wils | on Ford | | | | August | 25 199 | 95 10:55 | |
| | 4. SOCIAL SECURITY NUMBER | 30 - | in yrs. lest birthdey) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 7-14-14 0 | BIRTHPLACE (State or Form Country) | |
| | 214-22-3100 9e. FACILITY NAME (If not institution, give s | | BO YRS. | | | $\frac{9/13/1}{}$ | 914 1 | Maryland | |
| r | | | | | OR LOCATION OF D | EATH | | OF DEATH | |
| DIMECTOR | Westminster Nu | irsing Home | , | Westmi | inster | | Cai | rroll | |
| HE L | 10e. STATE 10b. COUNT | Υ | 10c, CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY | |
| | | roll | | Finks | ourg | | | 1 TES 2 N | |
| Ž. | 10e. STREET AND NUMBER | | | 10 | M. ZIP CODE | | | N OF WHAT COUNTRY? | |
| FUNERAL | 2916 Cedar Hur | 12. WAS DECEDENT EVER IN | | | 21048 | | | ited State | |
| | 1 Never Merried 2 X Merried | FORCES? 1 XYES | 2 NO | if yes, s | pecify Cuban, Mexico | NIC ORIGIN? (Specify ten, Puerto Rican, etc.) | fes or No- 14 | . RACE — American Indian Black, White, etc. | |
| 0 | 3 Widowed 4 Divorced | WWII | | 1 1 16 | S 2 XNO Specif | у. | | white | |
| EIED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S (Give kind of v | vork done during m | ON ost of working | 16b, KIND OF E | USINESS/INDUS | TRY | |
| 1 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Iffe. Do NOT us | e retired.) | 55.00 | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Elect | trician | - | | | L Contract | |
| 2 | , , , , , , , , , , , , , , , , , , , , | Ford | | | Ida | ME (First, Middle, Maid | racev | | |
| 20 | 19e. INFORMANT'S NAME (Type/Print) | rord | 19b. MAILING | ADDRESS (Street | | Route Number, City or To | | oriei | |
| 2 | Rosella Ford | | 4 | | | | | g, MD 210 | |
| | 20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo | 20b. | | | ame8/28/9 | | OCATION - CITY | | |
| | 4 Donation 5 Other (Specify) | | | | | rdens F | inksb | ıra. MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | neral Ho | | | |
| | Katherene 4 | Ritto - Nucita | 1 | | | | | stminster. | |
| | 23. PART I. Enter the diseases, or o | complications that caused | the death. Do n | ot enter the mo | ode of dying, suc | h as cerdiec or res | piratory srrest | , Approximat | |
| ı | IMMEDIATE CAUSE (Finel | Color of Cabas of G | ion inte. | , | | | | Onset and | |
| | disease or condition resulting in death) | · Correr | 177 | ung | | | | 3m | |
| | | DUE TO (OR AS A | confeautinat or | 1,1 | | | | 2 + | |
| 5 | Sequentially list conditions, if any, leading to immediate | D. OUE TO (OR AS A | CONSEQUENCE OF | no | 38 | | | 80 9 | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | |
| | that initiated events | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | |
| | PART II. Other significant condition | s contributing to deeth be | ut not resulting i | n the underlyin | g ceuse given in | Part i. 24a. WAS A | N AUTOPSY | 24b. WERE AUTOPSY FINE | |
| DICAL | | | | | | PERF | ORMED? | AVAILABLE PRIOR TO COMPLETION OF CA | |
| MEC | | | | | | | Z NO | OF DEATH? | |
| | DID TOBACCO USE CONTR | RIBUTE TO CAUSE OF | F DEATH YE | S I NO | UNCERTAI | N D | | 18 120 5 2 110 | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | | | | | | |
| 2 | 1 TYES 2 NO | 1 Inpetient 2 ER/Outpe | | | ne 5 🗆 Residence | 6 Other (Specify) | | | |
| - 1 | 27. MANNER OF DEATH 1. Natural 5 Pending | (Month, Day, Year) | 28b. TIME INJU | URY WO | JURY AT ORK? | 28d. OEŞCRIBE HOW | INJURY OCCUR | ED | |
| ā | 2 Accident Investigation 3 Suicide Could not be | 28s. PLACE OF INJURY | At home farm is | | YES 2 NO | 201 LOCATION (Or | t and March as as i | 0 | |
| | 4 Homicide 8 Could not ba | building, etc. (Speci | (y) | treet, rectory, orne | | 281. LOCATION (Stree City or Town, Stat | | rtural Pioute Number, | |
| | 290. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my knowle | edge death accurre | d at the time date | and place and due | T- #1 | 010 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | |
| COMPL | | R: On the basis of examination | | | | | | tupe(s) end menner se stat | |
| ы В | 296. SIGNATURE AND TITUE OF CERTIFIER | | | | 29c. LICENSE NUI | | | GMED (Month, Date Year) | |
| ٥ | Golfm mid | telm | | | DX | 43 | DATE SI | 13470T | |
| 2 | 30. WAME AND ADDRESS OF PERSON WHO | | | | X - 7 1 | | 0 | -311) | |
| | | leton, Pool | | | minster | , MD | | | |
| | 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | | | | | | |
| | AUG 2 8 1995 | Alia d'Audion | 201.11 | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Michin, List) 2. DATE OF DEATH MICHTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------|--------------------------------|---------------------------|--------------------------------------------------|---------------------------------------------------------------|----------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------|
| | John | Warren | | nk | | | | | August | | 995 | 11:50 A |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (By ye | | | | t. Inst birthday) YRS. | IF UNDER 1 YE MONTHS OV | CAR IF UR | HDER 24 HTML. | / DATE OF BIRTH (Mon) Feb. 15, | 1000 | B. BUTTH Countr | PLACE (State or Foreig |
| | 9s. FACILITY NAME (If not i | | The second second | 66 | 160. | | | | | | | lifornia |
| ۳. | Frederick | | | tal | | | ederi | CATION OF D | EATH | | eder | |
| 6 | RESIDENCE OF DE | CEDENT | | LUL | | TI | cuerr | CR | | 1 11 | eder | ICK |
| DIRECTOR | 10a. STATE | 10b. COUNTY | | | 12.22.23 | , TOWN OR L | | | | | 5.1 | 10d. INSIDE CITY LIMITS? |
| | Maryland Frederick Walkersville | | | | | | | | 1 YES 2 NO | | | |
| ERAL | 221 Sandsto | t | ivo | | | | 101. ZIF C | 1793 | | 12.308 | | WHAT COUNTRY? |
| FUNE | 11. MARITAL STATUS | one br | 12. WAS DECEDEN | IT EVER IN U.S | L ARMED | Ta, WAS | | | NC ORIGIN? (Specify Y | | | States |
| B | 1 Never Married 2 2 3 Wildowed 4 Div | | FORCES? 1 | WAR OR DATES | NO | If ye | s, specify C | ND Specif | m, Puerto Rican, etc.) | | Black | , White, etc. |
| TED | 15. DEI (Specify on | CEDENT'S EDU by highest grade | CATION completed) | 16a | Give kind of a | ont done durin | PATION or most of no | prking | 166. KIND OF B | USINESS/IND | USTRY | |
| COMPLET | Elementary/Secondary (| | College (1-4 or 5- 5+ | +) | Mis. Do NOT as | e retired.) | | | 199-09 | | | |
| JMF. | 17. FATHER'S NAME (First, A | Michigan (austi | J+ | | Doctor | | | | cine | | | |
| E CO | Warren | | Funk | | 18. MOTHER B NAME (FO | | | | me prot Motor Motor en Stare | n Sumanuj | | |
| m | 19s. INFORMANT'S NAME (| THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN 1 | WILL. | | 196, MAILING | ADDRESS (St | reet and Nurr | | Route Mumber City or To | wrt. State. Zin | Codel | |
| 2 | Donna Race | e Funk | | | | | | | Walkersvi | And the second | | 21793 |
| | 26a. METHOD O€-DISPOSIT | TION | comi from State | | CE AND DATE O | FOISPOSITIO | | 2.0 | | OCATION — | | |
| | 4 🗆 Donation 5 🗆 Othe | Hag | erstow | n Cren | natory | у 8 | 3/23/95 H | agers | town | , Maryla | | |
| | 21. SIGNATURE OF FUNERAL SERVICE CICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer | | | | | | | r Fun | era1 | Homes. | | |
| | 23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | . MD 21 | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| MEDICAL CE | PART II. Other significa | ent condition | s contributing to | death but n | ot resulting i | n the under | tying caus | ie given in | PERFO | HIMED? | 245. | WE'RE AUTOPSY FIND AWAILABLE PRIOR TO COMPLETION OF GAL |
| H H | | | | | | | | | OF DEATHS | | | |
| ä | DID TOBACCO L | | RIBUTE TO CA | | *** | | | VCERTAI | V 🗆 | | | 77 |
| SICIAN | 25. WAS CASE REFERRED 1 EXAMINER? | TO MEDICAL | HOSPITAL: | 26. P | LACE OF DEAT | OTHER: | orne) | | | | | |
| 1YS | 1 YES 2 NO | | 1 Inpetient 2 | | - | ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other | | | | The state of the s | | |
| ву рну | 1 Netural S 2 Accident | Pending Investigation | 28s. DATE OF (Month, D | ley, Weer) | 266, TIME INJU | M t | c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED TO THE YES 2 NO | | | | | |
| 8 | 3 Suicide 6 | Could not be determined | building, | # INJURY — A etc. /Specify) | t home, farm, e | rwet, factory, | office | | 281. LOCATION (Street City or Town, State | and Number | or Plural Pl | cute Number |
| PLET | 29s. CERTIFIER (Chock only one) 2 MEDICAL EXAMINER: To the heat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the heats of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner 29b. BIGNATURE AND STILE OF CERTIFIER 29c. LICENSE MUMBER 29d. DATE SIGNED (Month, Day, X | | | | | | | | | | | |
| TO BE COMP | over 2 MED | | | hn | | | _ | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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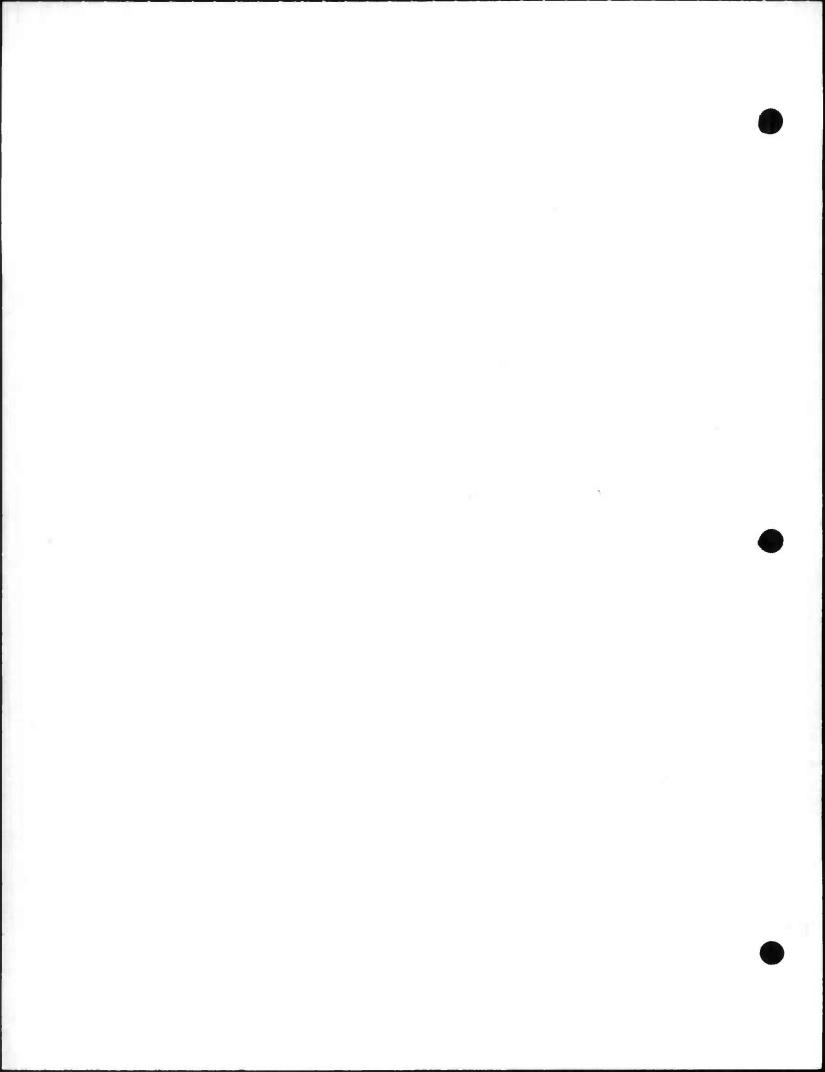
| | FOR STATE REGISTRAR | STATE OF MARYL | | ARTMEN' | | | | MENTAL HYG | | | | |
|------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|------------------|------------------------------------|--------------|-----------|-----------------------|---------------|------------|-------------------------------------|---------|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEAT | TH | | 3. TIME OF DEA | TH |
| | Ge | eorge Ful | ler, S | Sr. | | | | August . | L6. 1 | 995 | 5:50 | AM |
| | 4. SOCIAL SECURITY NUMBER 5 | S. SEX 8. AGE | (In yrs. lest birthe | | | IF UNDER | | 7. DATE OF BIRT | Н | 8. BIRTI | IPLACE (State or F | |
| | 577-20-8308 | M 2 F | 89 YF | S. MONTHS | DAYS | HOURS | MIN. | March 2, | | Was | m hington | D.C. |
| | 9e. FACILITY NAME (If not institution, give street | et and number) | | 9b. CITY | , TOWN C | R LOCATIO | ON OF O | | | INTY OF C | | 2101 |
| FUNERAL DIRECTOR | Manor Care | | | Be | thes | da | | | Мо | ntgo | mery | |
| 5 | RESIDENCE OF DECEDENT 100. STATE 10b. CDUNTY | | Lo | CITY, TOWN (| | | | | | | | |
| H H | 100.000111 | gomery | 100. | Rock | | | | | | | 10d. INSIDE CIT | |
| 7 | 10e. STREET AND NUMBER | gomer y | | KOCK | | . ZIP CODI | | | | | 1 TES 2 | NO |
| RA | 4719 Wyaconda Road | | | | 101 | 208 | | | 10g. CIT | | WHAT COUNTRY? | |
| N. | | 2. WAS DECEDENT EVER I | NUS ARMED | 12 | WAS DEC | | | HC ORIGIN? (Specif | Was as No | | USA | _ |
| F | 1 Never Merried 2 Married | FORCES? 1 YES | 2 NO | | If yes, spe | cify Cuba | n, Mexica | n, Puerto Rican, sto | | Black | E — American Indi k, White, stc. | len, |
| ВУ | 3 X Widowed 4 Divorced | Ünknown | ALES | | I YES | 2 🔀 NO | Specifi | y: | | Spec | " White | - 1 |
| <u>E</u> | 15. OECEDENT'S EOUCAT (Specify only highest grade cor | TION moleted) | 18e. DECEDE | T'S USUAL O | CCUPATIO | N . | | 16b. KIND O | F BUSINESS/IN | DUSTRY | | |
| <u>-</u> | | College (1-4 or 5+) | life. Do No | OT use retired.) | duning mo | st or workin | g | | | | | |
| MP | Unknown | | Stati | sticia | an | | | Unkn | own | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTH | HER'S NA | ME (First, Middle, Mi | elden Sumeme) | | | |
| BE | Unknown | | | | | | U | nknown | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | Route Number, City o | | | | |
| | J. Laurence Kent | | 5259 | Exect | ıtiv | e Blv | vd. | Rockvill | e, Mar | ylan | d 20852 | |
| | 20s, METHOD OF DISPOSITION 1 N Buriel 2 Cremetion 3 Remove | of from State | PLACE AND D | TEOF DISPOS | ITION /Na | me of | | DATE 20 | . LOCATION - | City or To | wn, Stata | |
| | Gate of Heaven Cemetery 8/18/95 Silver Spring, Maryland | | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. | | | | | | | | | | | |
| | 500 Unviersity Blvd.W. Sil.Spr. MD 20901 | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or con | nplications that cause | the death. I | o not enter | the mo | de of dyl | ng, suc | h as cardiac or i | espiratory ar | rest, | Approxim | ate |
| 0 | shock, or heart failure. Lis IMMEDIATE CAUSE (Finel | 01/ | | | | | | | | | Onset and | |
| | disease or condition resulting in desth) | CART | DIOF | ULM | ON | 120 | 1 | FAIL | TRE | , | | |
| | in destily | DUE TO (OR AS A | CONSEDUENC | E OF): | | 7 ! | <i>L</i> | ,,,, | | | | |
| Z | C b. | Se | PSIC | , | | | | | | | | |
| Ĕ | Sequentially list conditions, if any, leading to immediate | DUE TO (DR AS A | | E OF): | | | 0 | · TRen | + . | | | |
| 2 | CAUSE (Disease or Injury | GANG | Rel | | -04 | ver | 2 | e licen | 1 100 |) | |] |
| E | that initieted events resulting in death) LAST | DUE TO (DR AS A | CONSEQUENC | E OF): | | | | | | | | - 1 |
| CERTIFICATION | d | | | | | | | | | | | |
| AL | PART II. Other algnificent conditions of | contributing to death b | ut not resulti | ng in the un | deriying | cause g | lven in | Part I. 24a. WA | S AN AUTOPSY | 24b. | WERE AUTOPSY F | INDINGS |
| 5 | DIABETES | | | | | | | 1 YE | REDRIMED? | | COMPLETION DE | |
| MEDIC | HYPEZTEN | 15100 | | | | , | | | | | OF DEATH? | NO. |
| ż | DID TOBACCO USE CONTRIB | BUTE TO CAUSE O | F DEATH | YES 🗆 I | 10 X | UNC | ERTAIN | v 🗆 | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check gray-one) | | | | | | | | | | | |
| Si | | OSPITAL: | etlant 3 🗆 DO | A 4 Noun | R: olng Home | 5 🗆 Re | sidencs | 6 Other (Specify) | | | | |
| H | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. | TIME OF | 28c. INJU | | | 28d. DEŞCRIBE H | OW INJURY OC | CUREO | | |
| BY | 1 Natural 5 Pending investigation | 1,, | | М | | ES 2 | NO | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY — At home, farm, atreet, factory, office 28f. LOCATION (Street end Number or Rural Route Number, | | | | | | | | | | |
| 1 | 4 Homicide determined | | | | | | | City or Town, \$ | state) | | | |
| PLE | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my know | ledge, death oc | curred at the ti | me, date | and place, | end due | to the cause(e) end | menner en sta | led. | | |
| COMPLETED | | On the besie of examination | | | | | | | | |) end manner as s | tated. |
| E C | 290 OIGNATURE AND TITLE OF CONTINUES |) | | | Т | 29c. LICE | | | | | (Month, Day, Year) | |
| 0 | K.C. 1 4.46 | Exer in | n.D | | | DO | DIE | 10 | > < | 7/1 | 6/90 | _ |
| 인 | 30 NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DE | ATH (ITEM 27) (| Type, Print) | | | - 1 4 | 1 | | 2/_/_(| 1112 | |
| | KOKERT (, 1) | ADDARI | 0 40 | 130 | 120 | RI | 14 | Ave | KOTILO | SDA | WI) 20 | 814 |
| - 11 | (COBERT C. DADDARIO 4930 TEL RAY AVE KUTUESDA, INDERSIY | | | | | | | - | Muc | -11-1 | 1111 | - 1 1 |
| 1 | 31. DATE FILED (Month, Day, Year) | 32. HEGIST HAM'S SIGN | Aluna | , | AUG 22 1995 Julia Davidson Randall | | | | | | | |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within T4 hours after death. Page 6 may be retained by the hospital or attending physician. | |
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| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
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| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAND / (| | OF HEALTH AND | MENTAL HYGIEN | | |
|------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------|-------------------------------------------------|----------------------------|------------------------------|--------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | EdMAN | | | 2. DATE OF DEATH BY AUGUST | YEAR | 3. TIME OF DEATH 12:45 AM |
| | 4. SOCIAL SECURITY NUMBER 5. SET | | birthday) IF UNDER | 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 17 1995 8. BIRT | NPLACE (State or Foreign |
| | 102-03-2254 X 9e. FACILITY NAME (If not institution, give street end | M 2 □ F 79 | YRS. MONTHS | DAYS HOURS MIN. | AUG. 8, 19 | | YORK |
| OR | SHADY GROVE NURSING | | | KVILLE | DEATH | MONTGON | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN | OR LOCATION | | | 10d. INSIDE CITY |
| | MARYLAND MONTGOME 10s. STREET AND NUMBER | RY | ROCKVII | LE 101, ZIP CODE | | | LIMITS? |
| FUNERAL | 9701 MEDICAL CENTER | DRIVE | | 20850 | | UNITED | STATES |
| P.C. | | AS DECEDENT EVER IN U.S. ARMI DRCES? 1 YES 2 NO | | WAS DECENDENT OF NISPA | | or No.— 14, RAC | E — American Indian, |
| BY | | YES, GIVE WAR OR DATES | | If yes, specify Cuben, Mexic 1 YES 2 NO Spec | | | WHITE |
| E | 15. DECEDENT'S EDUCATION (Specify only highest grade complete | (Give | EDENT'S USUAL O | CCUPATION during most of working | 16b. KIND OF BUS | INESS/INDUSTRY | |
| P | Elementary/Secondary (0-12) Coffee 12 | ge (1-4 or 5 +) | O NOT use retired.) | HER | РНОТОС | RAPHY | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Leet) | | - | | AME (First, Middle, Meiden | Surname) | |
| BE | ABRAM FRIEDMAN 198. INFORMANT'S NAME (Type/Print) | | | | ANKELEWITZ | | |
| 2 | CAROL MILLMAN (DAUGH | TER) 7 | | TER, BERWYN | | | .2 |
| | 20a METHOD OF DISCOUTTON X Burlal 2 Granuation 3 Removal fro 4 Donation 9 Ditter (Specify) | m State 20b. PLACE AN | DNIEFIOR | E CEMETERY | | CATION — City of TO | NEW YORK |
| | 21. SIGNATURE OF FINERAL SERVICE LICENSEE | // | DÃ | NAME AND ADDRESS OF F | | | |
| | Bary M. | Thise | 11 | 70 ROCKVILL | E PIKE-ROCK | VILLE, M | |
| | 23. PART 1 Enter the disease, or compile shock, or heart allure. List on IMMEDIATE CAUSE (Final | fations that coused the dest ily one cause on each line. | th. Do not enter | the mode of dying, su | ch as cerdisc or respi | ratory arrest, | Approximate interval Between Onset and Dazth |
| - | disesse or condition resulting in death) a | Preumon DUE TO (OR AS A CONSEQU | ia | | | | · 17 days |
| z | | Aseiration | ENCE OF J: | | | | 3 west. |
| ATIO | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO OR AS A CONSEQU | | 01 | | | 17 days 3 weeks 15 years |
| CERTIFICATION | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CONSEQU | - Bulba | r Palsy | | | 15 years |
| ERT | resulting in deeth) LAST | | | | | | |
| AL C | PART II. Other significant conditions contr | ributing to deeth but not res | uiting in the ur | derlying cause given in | Part I. 24s. WAS AN | | . WERE AUTOPSY FINDINGS |
| DIC | Partenson's Piscase | | | | PERFOR | MEO! | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDIC | DID TODA COO HOT COA TENANT | | | | | ^ | 1 YES 2 NO |
| AN | DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL | | OF DEATH (Check | | IN 🗆 📗 | | |
| SIC | | PITAL: ipatient 2 ER/Outpatient 3 E | QTHER | | 8 Other (Specify) | | |
| 표 | 27. MANNER OF DEATN 20 1 1 2 Natural 5 Pending | 8e. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 28c, INJURY AT WORK? | 28d. DESCRIBE NOW IN | JURY OCCURED | |
| BY | 2 Accident Investigation | 6e. PLACE OF INJURY — At home | , farm, street, fact | 1 YES 2 NO | 261. LOCATION (Street e | nd Number or Burel i | Bouto Number |
| ETEC | 4 Homicide 6 Could not be | building, etc. (Specify) | | | City or Town, Stele) | TO NOTION OF THE PROPERTY OF | Name Herrices, |
| COMPLETED | | the best of my knowledge, death | | | | | s) end menner ee stated. |
| 8 | 29b. SIGNATURE AND TOP OF CERTIFIER | lu mo | - | D 3/ | | 29d. DATE SIGNED | (Month, Day, Year) 95 August, 17, 1995 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMP | LETED CAUSE OF DEATH (ITEM : | 27) (Type, Print) | - Drive, Sute | 214 Lockui | 1. MO 2 | 0850 |
| | | 2. REGISTRAP'S SIGNATURE Julia d'Avellon Ron | | - Mo Jour | | / | |
| | AUG 22 1995 | Jama andress was | all | | | | |

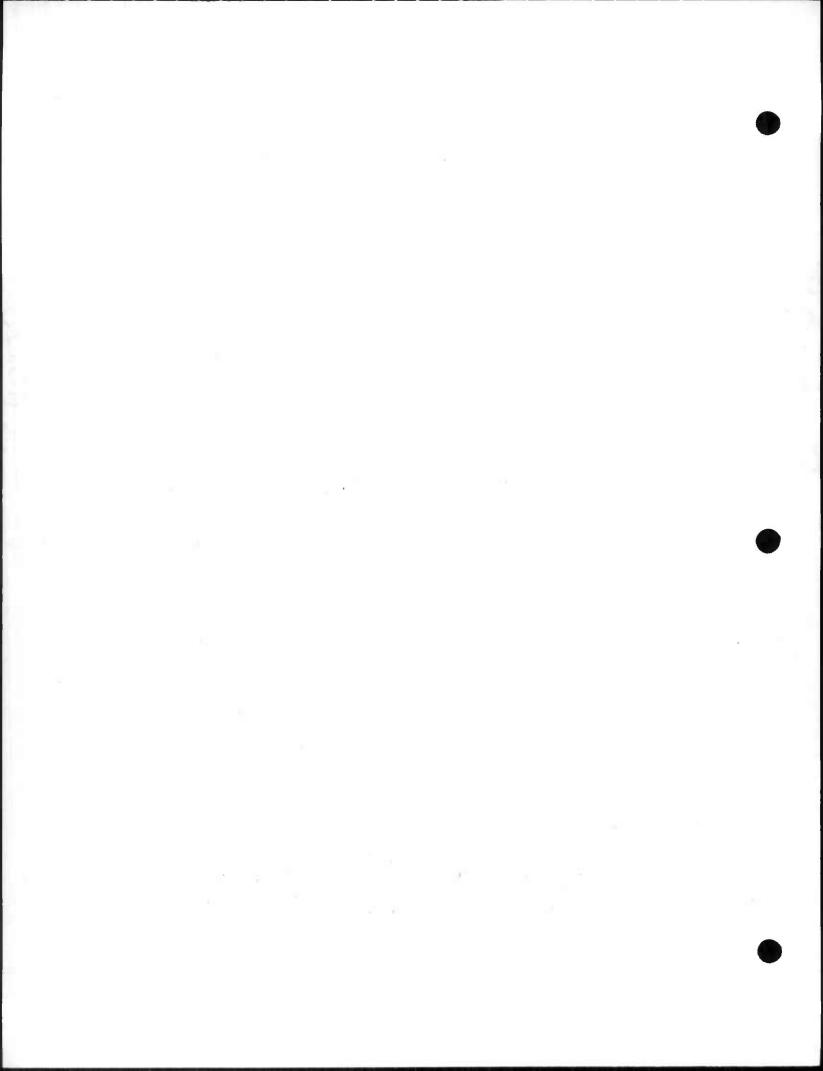


the hospital or attending physician. efetached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| fler death. Page 6 may be retained by the hosp | the funeral director, page 5 should be detached | oval. | al examiner must be notified at once. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | EALTH AND | MENTAL HYGIEN | | | |
|--------------------|-------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------|---------------------|------------------------------------|------------------------------------------|---------------------|---------------------------------------------|-----------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 7.1.1 | DEATH | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| | WILLIAM ELDRIDGE | FROMAN, SR. | | | | AUGUST 20 | 1995 | 3:45 A | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign | \dashv |
| | 577-01-2997 | | 35 YRS. M | ONTHS DAYS | HOURS MIN. | April 1,1 | 910 Vir | ginia | - 1 |
| | 9a. FACILITY NAME (If not institution, give str | reet and number) | = | b. CITY, TOWN | R LOCATION OF D | | 9c. COUNTY OF | | 7 |
| DIRECTOR | 1914 Brisbane Str | eet | | Silve | r Sprin | g | Montg | omery | -1 |
| S S | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c, CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | \exists |
| DIR | Maryland Mo | ntgomery | | | Spring | | | LIMITS? | |
| | 10e. STREET AND NUMBER | regomery | | | ZIP CODE | | tog, CITIZEN OF | WHAT COUNTRY? | \dashv |
| FUNERAL | 1914 Brisbane Str | eet | | | 20902 | | | 5.A. | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | | | ENDENT OF HISPA | NIC ORIGIN? (Specify Yes | or No- 14, RAC | E - American Indian, | \dashv |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? t YES | | | city Cuben, Mexico 2 D ND Speci | en, Puarto Rican, etc.) ly: | Spe | ck, White, atc. | П |
| | | | | 1 | | | | White | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | completed) | 16a. DECEDENT'S US (Give kind of world) life. Do NOT use | k done durina ma | IN at of working | 16b. KIND OF BU | SINESS/INDUSTRY | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Foreman S | | | m - 1 1 | | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | roreman 3 | upervis | | Telepl | | | 4 |
| Ö | Elridge Cleveland | Froman | | | | rrie Marti | | | |
| BE (| 19a. INFORMANT'S NAME (Type/Print) | I I Omaii | 19b. MAILING A | DDRESS (Street a | | Route Number, City or Tow | | | \dashv |
| 5 | William E. Froman | , Jr. | 1 | | | lin, Maryla | | 11 | П |
| | 20e. METHOD OF DISPOSITION t | 201 | PLACE AND DATE OF | DISPOSITION (Na | | | CATION — City or 1 | | 7 |
| | 4 Donalion 5 Other (Specify) | Fc | ort Lincol | rplaca) n Cemet | ery 8 | /22/95 Bren | ntwood. 1 | Marvland | 1 |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | ENSEE | | 22. NAME AP | D ADDRESS OF FA | Clury Llins Fune: | | | 7 |
| | Vinnethy | 1 x Can | stell | | | y Blvd.,W. | | | |
| | 23. PART i. Enter the diseases, or co | omplications that cause | d the death. Do not | entar the mo | da of dying, suc | h as cardisc or reep | ratory erreat, | Approximate | 4 |
| | shock, or heart failure. L IMMEDIATE CAUSE (Final | M. Parking | 27-2-11-71 | | | | | Onset and Death | |
| | disease or condition resulting in death) | METAST | ATIC | SMA | LL CE | IL WNG | CANO | R 10 MO | M |
| | | DUE TO (OR AS | CONSEQUENCE OF): | | | | | | 1 |
| NO | Sequentially list conditions, | 215 | | | | | | | |
| AT | if any, leading to immediate cause. Enter UNDERLYING | DOE TO (OH AS) | CONSEQUENCE OF): | | | | | | |
| 띮 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS / | CONSEQUENCE OF): | | | | | | - |
| CERTIFICATION | resulting in death) LAST | | | | | | | | Т |
| | PART ii. Other significant conditions | contribution to death t | | | | - 1 | | | |
| PHYSICIAN: MEDICAL | TANT II. Othar significant conditions | contributing to death c | ut not resulting in | tha underlying | cause givan in | Part I. 24e. WAS AN PERFOR | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| | | | | | | 1 YES 2 | M NO | COMPLETION OF CAUSE OF DEATH? | |
| Σ | DID TOBACCO USE CONTR | IDLITE TO CALICE C | E DEATH VEC | | LINICEDTAL | - T- | | 1 TES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | IBUTE TO CAUSE C | 26. PLACE OF DEATH | | UNCERTAI | N M | | | 4 |
| Sici | EXAMINER? | HOSPITAL: | | THER: | - | V | | | \dashv |
| H | 27. MANNER OF DEATH | 28e. DATE OF INJURY | 28b. TIME | | | 8 ☐ Other (Specify) 28d. DESCRIBE HOW I | NULTRY OCCUPED | | 4 |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | Y WO 1 □ 1 | RK? | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | - At home, farm, etre | et, factory, office | | 281. LOCATION (Street I | and Number or Rural | Route Number, | + |
| COMPLETED | 4 Homicide determined | ballottig, etc. (Spot | -1197 | | | City or Town, State) | | | |
| 2 | 29a. CERTIFIER 1 CERTIFYING PHYSIC | IAN: To the best of my know | ledge, death occurred | at the time, date | and place, and due | to the ceuse(a) and mar | mor as stated. | | 1 |
| MO | | : On the beele of examination | | | | | | a) and manner as stated, | |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | MBER | 29d. DATE SIGNE | (Month, Day, Year) | + |
| O BE | men | our Ms | | | D 33 | 224 | | ST 21, 1995 | 1 |
| 9 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Pr | int) | | | | | |
| | R Trehan Mu | 2 70M 8 | -amou- | cton E | Y 7 401 | , Rocke | rue M | D 2017 2 | د |
| | 31. DATE FILED (Month, Day, 'Hear) | 32 REGISTRAR'S SIGN | ATURE | | | | | | 1 |
| | AUG 23 1995 | Harry androgen | randall | | | | | | |



| BALTIMORE, MARYLAND 21215-0020 | 4 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | e medical examiner must be notified at once. |
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| | | | | | | | 95 2/060 |
|---------------|-----------------------------------------------------------------------------|-------------------------|--------------------------------------------------|---------------------------------------|-------------------------------------------------|-------------|---------------------------------------------------|
| | 1 - FOR STATE OF MARY | LAND / DEPAR | RTMENT OF H | EALTH AND | MENTAL HYGIEN | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Datis Jana COTCH | | | | MONTH D | | YEAR |
| | Dotis Jane GOTCH 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | August 17 | , 19 | 95 7:00P M a. BIRTHPLACE (State or Foreign |
| | 555 00 1105 | 7 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | 007 | Country) |
| | |) / | | | Oct. 23, 1 | | Washington, DC |
| - | 9a. FACILITY NAME (If not institution, give atreet and number) | | 9b. CITY, TOWN (| OR LOCATION OF E | DEATH | 9c. COU | INTY OF DEATH |
| 0 | Doctors' Community Hospital | | Lanham | | | Pri | nce George's |
| [] | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | I son CIT | Y, TOWN OR LOCAT | 71011 | | | |
| DIRECTOR | | | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Prince George's | В | ladensbu | - | | | 1 X YES 2 NO |
| A A | | | 1000 | , ZIP CODE | | | TIZEN OF WHAT COUNTRY? |
| FUNERAL | 5502 Volta Avenue | | | 20710 | | U.S | .A. |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER FORCES? 1 ☐ YES | IN U.S. ARMED | 13. WAS DEC | ENDENT OF HISPA ecity Cuban, Maxic | NIC ORIGIN? (Specify Yes | or No- | 14. RACE — American Indian, Black, White, atc. |
| B | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR I | DATES | | 2 NO Speci | | | Specify: |
| | 15. DECEDENT'S EDUCATION | | | | | | White |
| 1 !! | (Specify only highest grade completed) | (Give kind of | USUAL OCCUPATION work done during mose retired.) | on ast of working | 16b. KIND OF BUS | SINESS/INI | DUSTRY |
| 12 | Elementary/Secondary (0-12) Coffege (1-4 or 5+) | l . | | | D | 0 1 | |
| COMPLETED | | Antique | Dealer | | Retail | | S |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | AME (First, Middle, Melden | | |
| BE | Charles Spicer | | | Agnes | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | Route Number, City or Town | | |
| | John J. Gotch, Sr. | 5502 | Volta Av | enue, Bl | adensburg, | Mar | yland 20710 |
| | | b. PLACE AND DATE | | me of | DATE 20c. LO | CATION — | City or Town, State |
| | 4 🗆 Conetion 5 🗓 Other (Specify) M | State V | eterans | Cemeter | y 8/22/95 C | helt | enham, Maryland |
| | 21. BIGHADARE OF TUNERAL SERVICE LICENSEE | | 22. NAME AN | D ADDRESS OF F | ACILITY | | |
| | ► Ap. X.¥ (/ | | | | | | Home, P.A. |
| | 23. PART i. Enter the dispass, or complications that cause | d the death. Do | H/39 B | altimore | Ave., Hyat | tsvi. | lle, MD 20781 |
| | anock, or haart failure. List only one cause on | each line. | TOT BILLET ING THO | de or dying, ad | on as cardiac or reapi | ratory an | Interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | 01. | | | | | Onset and Death |
| | reaulting in death) | 2/1/2 | - 3h | ode | | | 3 de-6) |
| | DUE TO (OR AS | A CONSEQUENCE OF | F): | | . 1 = 1 | 1 | 7. 800 |
| NO. | sequentially list conditions, | A CONSEQUENCE OF | n (91 | nce - | Metasta | H] | - 2 W |
| F | if any, leading to immediate cause, Enter UNDERLYING | A CONSEQUENCE OF | ·): | | | | 3.0 |
| 2 | CAUSE (Disease or Injury | A CONSEQUENCE OF | | | - | | |
| Ē | that initiated events resulting in death) LAST | A CONSEQUENCE OF | r): | | | | |
| CERTIFICATION | d | | | | | | |
| | PART il. Other significant conditions contributing to death | out not resulting | in the underlying | g cause given in | | | 24b. WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | PERFOR | . / | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | 1 □ YES 2 | XNO | OF DEATH? |
| 2 | DID TOBACCO USE CONTRIBUTE TO CAUSE O | DE DEATH VE | S CI NO M | LINICEDTAL | | | 1 TYES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | 26. PLACE OF DEAT | | UNCERTAI | иП | | |
| PHYSICIAN: | EXAMINER? HOSPITAL: | | OTHER: | | | | |
| ¥ | 1 YES 2 NO 1 Inpetient 2 ER/Out 27. MANNER OF DEATH 28e. DATE OF INJURY | 26b. TIM | | | 6 Other (Specify) 28d. DESCRIBE HOW II | | Aug. |
| | 1 Natural 5 Pending (Month, Day, Year) | | URY WO | RK? | 26d. DESCRIBE HOW IF | NJURY OC | CURED |
| B | 2 Accident Investigation 3 Suicide 6 Could got by 28e. PLACE OF INJUR | Y — Al home form | | ES 2 NO | | | |
| 유 | 3 Suicide 6 Could not be determined 28e. PLACE OF INJUR building, atc. (Spe | cify) | erreet, rectory, orner | | 28f. LOCATION (Street a City or Town, State) | na Number | or Hurel Houte Number, |
| COMPLET | 29a, CERTIFIER | | | | | | |
| MP | (Check only CERTIFYING PHYSICIAN: To the best of my know | | | | | | |
| 00 | 2 MEDICAL EXAMINER: On the basis of examination | n and or Investigatio | n, in my opinion, d | eath occured at the | time, data and place, and | d due to If | ne cause(a) and manner as stated. |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NU | MBER | 29d. DAT | E SIGNED (Month, Pay, Year) |
| - | | 10 | 20 | 707 | コノつ・ナ | - N & | 5/12/5 |

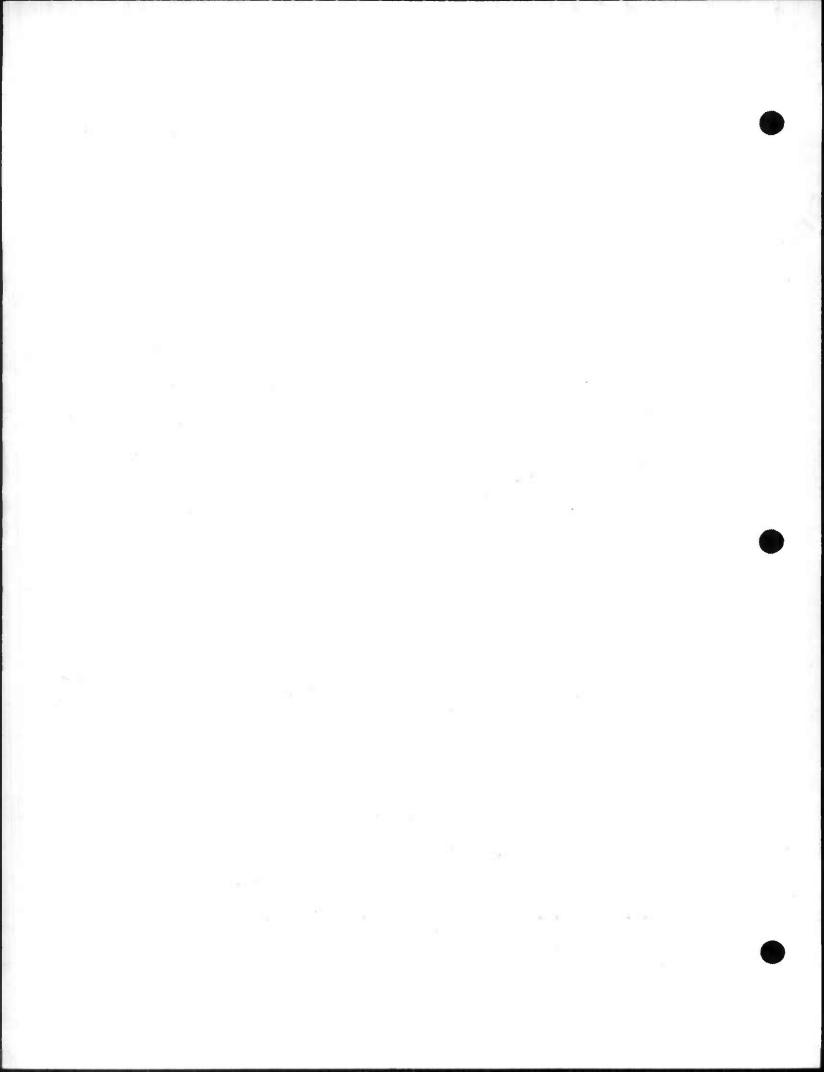
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

6504 Kenilworth
32 REGISTRAR'S SIGNATURE
Julia Dawlin harlal

Ave..

Riverdale, MD 20737

M.K. Mohan M.D 31. DATE FRIED (Month, Day, Ybar) AUG 22 1995

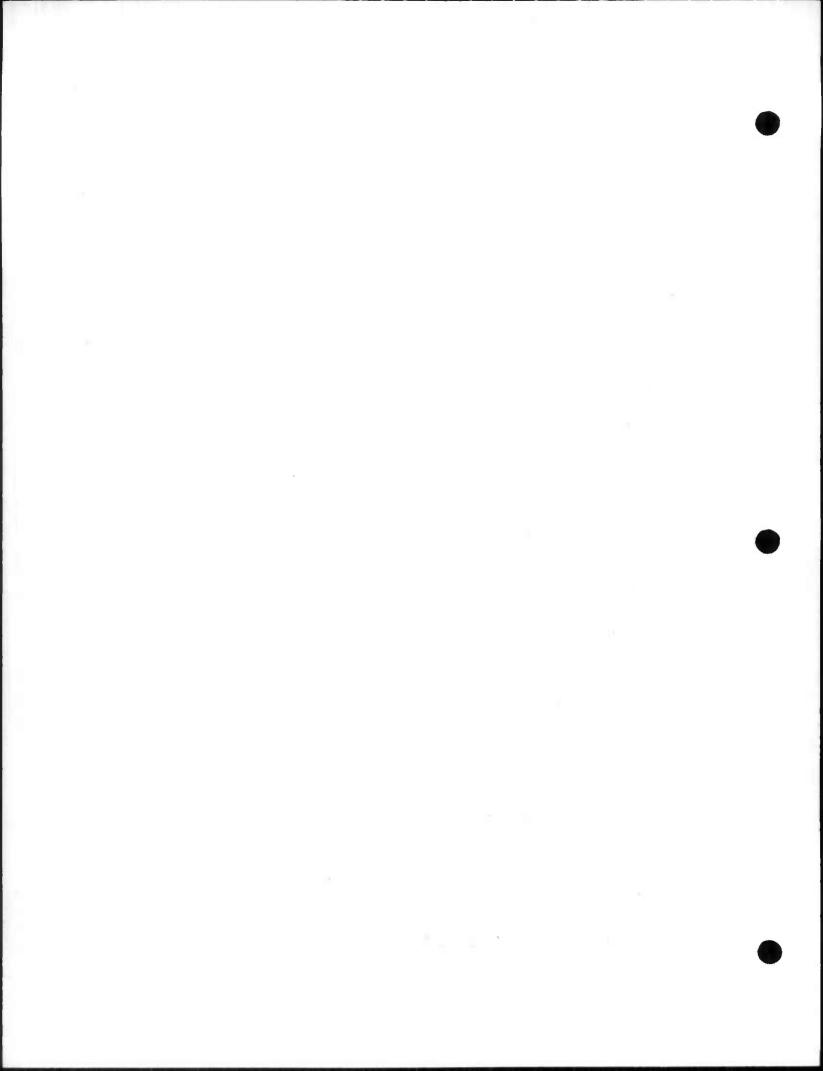


| TAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Ite has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should are Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | TO BE COMPLETED BY FUNERAL DIRECTOR | 4. SOCIAL SECURITY NUMBER 245-39-134 9e. FACILITY NAME (If not institute of prince Georgie Residence of Dece 10e. State 10e. Street and number 6827 Ingr 11. MARITAL STATUS 1 Never Merried 2 Maryland 3 Widowed 4 Divorce 15. Dece 16. Specify only in Elementary/Secondary (0-12. 12. T. FATHER'S NAME (First, Midd. Joseph Eac. 19e. Informant's NAME (Typ. Joycelyn She) 20. METHOD OF DUSTOSETTO 1 Middle 1 Gonstion 5 Other (St. Bidmature of Funeral 1 dignature of Funeral 1. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | shock, or hee IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if sny, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent DID TOBACCO USI 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide dei 29e. CERTIFIER (Check only one) 2 MEDICA 29b. CERTIFIER AND TITLE OF |

| | | | | | | | | | | | | 6/106 | 1 |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------|-------------|------------------|----------------------|------------|-------------------------------------|-----------------|-------------|------------|-----------------------------------------|----------|
| | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / CE | | TMENT OF | | | | YGIEN EG. NO | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF D | DEATH (| 7 | X | 3. TIME OF PENTH | 1000 |
| | Eunice L. Gra | nt | | | | | | | 16 | Ö | SEAR. | J.Wr | (YK(|
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lesi | t birthday) | IF UNDER 1 YEA | | | 7. DATE OF B | нтви | | S. BIRT | HPLACE (State or Foreig | ın |
| | 245-39-1345 | 1 🗆 M 2 🏝 F | 73 | YRS. | MONTHS DAY | 8 HOURS | MIN. | June | | 1922 | Goun | uyana | |
| | 9a. FACILITY NAME (If not institution, give a | itreet and number) | ·· | | 9b. CITY, TOV | N OR LOCATI | ON OF DE | | | | | | |
| DIRECTOR | Prince George's C | ommunity | Hospita | 1 I | Che | verly | v | | | Pri | nce | George's | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | | | | | | | | | | |
| E | | | | | , TOWN OR LO | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Prin | nce Geor | ge's | RIV | rerda1 | | | | | , | | 1 X YES 2 NO | |
| RA | | Chanal | | | | 101. ZIP CODI 207 | | | | 10g. CI1 | IZEN OF | J.S.A. | |
| FUNERAL | 6827 Ingraham | | | | | | | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| | 1 Never Married 2 Married | | YES 2XN | | | | | NIC ORIGIN? (Sp in, Puerto Ricen | | s or No— | 14, RAC | E — American Indian, ik, White, etc. | |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 10 | ES 2 XNO | Specify | y: | | | Spec | My: Black | |
| 0 | 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | _ | |
| ETI | (Sive kind of work done during most of working life. Do NOT use retired.) College (1-4 or 8 +) | | | | | | | | | | | | |
| PL | Housewife Private | | | | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | | |
| BE C | Joseph Eadie Clara Downer | | | | | | | | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | |
| 5 | Joycelyn Sheppard | l-Best | 6 | 827 | Ingrah | am Str | eet, | , River | dal | e, Ma | aryla | and 20737 | 7 |
| | 1 X Bugal 2 Cremation & Ram | and from firm | | | FDISPOSITION | | | BAJE. | 20c. LO | CATION - | City or To | own, Steta | |
| | 4 Constion 5 C Other (Special) | Over from Stelle | Harmon | ng Me | emoria: | Park | | 8/7/21 95 | Lar | ndov | er, | Marylan | d |
| | 21 SIGNATURE OF FUNERAL SERVICE LI | CENSEE |) | | 22. NAME | AND ADDRES | SS OF FA | oury ins Fu | noi | c | Uome | | |
| | X /-X | 5 / | / | | | | | ver Rd | | | | | 5 |
| | 23. PART I. Enter the diseases, or | conjunity that | -esusad the day | ath. Do n | ot enter the | node of dvi | navaud | h as cardiac | or/reso | instory as | met. | Approximate | |
| | IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | eath. | |
| 8 . | resulting in death) OUE TO 10R AS A CONSEQUENCE OF: | | | | | | | | | | | 1 | \dashv |
| z | - Commun threw Disease | | | | | | | | | | | | - 1 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | OUE 10 | OR AS A CONSED | UENCE OF | .0 | , | - | 2000 | ~~ | - | | | \neg |
| 3 | cause. Enter UNDERLYING CAUSE (Disesse or Injury | NU | RUSGY | -UM | Sie | \wedge | 1 | | | | | | |
| E | that initiated events | DUE TO | OR AS A CONSEQ | UENCE OF | H | | • | | | | | | |
| E | resulting in death) LAST | d. | | | | | | | | | | | |
| | PART II. Other significent condition | s contributing to | death but not re | sulting i | the underly | lag cours o | ni manin | Bort I I no. | W00 444 | ALITTORION | Lan | | |
| ₹ | | | | outing i | Title underly | ing couse g | liveii iii | Part I. 248. | PERFOR | AUTOPSY | 240 | AMILABLE PRIOR TO | ı |
| | | | | | | | | ' [| YES 2 | - Alio | | OF DEATH? | |
| Σ | DID TORACCO LICE CONT | DIBLITE TO CA | 100 00 00 11 | | | | | | | | | 1 YES 2 NO | - 1 |
| PHYSICIAN: MEDICAL | DID TOBACCO USE CONT | RIBUTE TO CA | | | H (Check only o | | ERTAIN | 4 L | | | | | _ |
| 2 | EXAMINER? | HOSPITAL: | | | OTHER: | | | | | | | | \dashv |
| ξ | 27. MANNER OF OEATH | 1,80 Inpatient 2 28a. DATE OF | | 28b. TIME | | Ome 5 Re | sidence | 6 Other (Spe | | | | | |
| | 1° Netural 5 Pending | (Month, De | | INJU | IRY | WORK? | 7 100 | 28d. OEŞCRIB | E HOW I | NJURY OC | CURED | | - 1 |
| B | 2 Accident Investigation 3 Suicide & Could get be | 28e. PLACE Of | FINJURY — At hon | ne ferm e | | YES 2 | NO | 284 OCATION | 1 (01 | | - 0 | | |
| | 4 Homicide 6 Could not be | building, | etc. (Specify) | ,, | reet, tectory, o | 1100 | | 28t. LOCATION City or You | vn, State) | una Numbe | or Hurai i | toute Number, | |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| Z | (Check only one) 2 MEDICAL EXAMINATION | | | | | | | | | | | | |
| 8 | | | A and/or in | restigation | , in my opinior | , death occur | ed at the | time, data and p | piace, an | d due to th | e cayee(s | and manner as stated | d. |
| # | 296. GIGHATURE AND TITLE OF CERTIFIER 29d. GATO SIGNED MORE (September 29d. GATO SIGNED MORE) (September 29d. GATO SIGNED MORE) | | | | | | | | | | | | |
| 9 | 30. HAME AND ADDRESS OF PERSON WIL | O COMPLETED CAUS | MM/180/ | 1 | 111 | 100 | 1 | 11 | | 1 | > 1 | ULYS | |

Joseph R. Robinson 10274 Lake Arbor Way Mitchellville, Md 20721

32. REGISTRAR'S SIGNATURE



9:30

a. BIRTHPLACE (State or Foreign

Arkansas

Prince George's

10g. CITIZEN OF WHAT COUNTRY?

Specify:

Landover, Md

United States

RACE — American Indian, Black, White, etc.

3. TIME OF DEATH

10d. INSIDE CITY

Black.

Approximate

Interval Betwe

Onset and Death

YR

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

Day,

20785

5

OF DEATH?

29d. DATE SIGNED (Month,

CORPORATE DR. LAWDOUER LUD

1 X YES 2 NO

2. DATE OF DEATH

August 21,

1995

9c. COUNTY OF DEATH

FOR STATE REGISTRAR

JAMES

1. DECEDENT'S NAME (First, Middle, Last)

| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | | |
|-------------------------------------------|---------|--|
| F VITAL RECORDS, P.O. | 68760 | |
| F VITAL RECORDS, P. | BOX | |
| F VITAL RECORD | - " | |
| FVIT | RECORDS | |
| DIVISIONO | FVIT | |
| DIVIS | ONO | |
| | DIVIS | |

4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS HOURS MIN. 1 👽 M 2 🔲 F YRS March 17, 1945 431-80-2721 50 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 2717 Country Club Road Hvattsville RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Prince George's Maryland Hyattsville permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE use as the burial-transit 2717 Country Club Road 20785 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 11 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Maxican, Puarto Rica

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during i life. Do NOT use retired.) funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) 3 Manpower Specialist Government 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 16 James Gardner, Sr. Willie Reen Phillips BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5801 Spring Valley, #1316W, Dallas, Texas 75240 Travis Gardner 2 20s. METHOD OF DISPOSITION
1 | Burlal 2 | Cremetton 3 | Removal from State
4 | Donatton 8 | Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must retery, crematory or other place) Harmony Memorial Park 8/23/95 examiner 21. SIGNATURE OF FÜNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home death. 4001 Benning Rd., N.E. Wash., D.C. 20019 the state of hours after o medical Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by shock, or heart fallure. List only one cause on each line. 6 IMMEDIATE CAUSE (Final completely filled rial, cremation, the state of disease or condition_ SARCOMA resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): executed and com traumatic CERTIFICATION Sequentially ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to the attending physician Mental Hygiene prior to if any, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST 6 the death injury. PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY has been signed by the Dept. of Health and I that any 1 TYES 2 TI MOT Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h tem HOSPITAL: OTHER: 1 | YES 2 | NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural М 1 YES 2 NO DIRECTOR; After the hours after death was BY Investigation 2 Accident ATTENDING 28a. PLACE OF INJURY — At home, farm, street, tactory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 8 Could not be COMPLETED 4 Homicide 28 tem 80 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. FUNERAL I HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE D18219 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8300

32/REGISTRIAR'S SIGNATURE

STANC

STEPHEN

GARDNER, JR.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

FOR

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

D #17 8/21/95 HIM PGC ITEMS: 23 PART II, 27, 28a-f, PER MEO FILM G-728 10/25/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

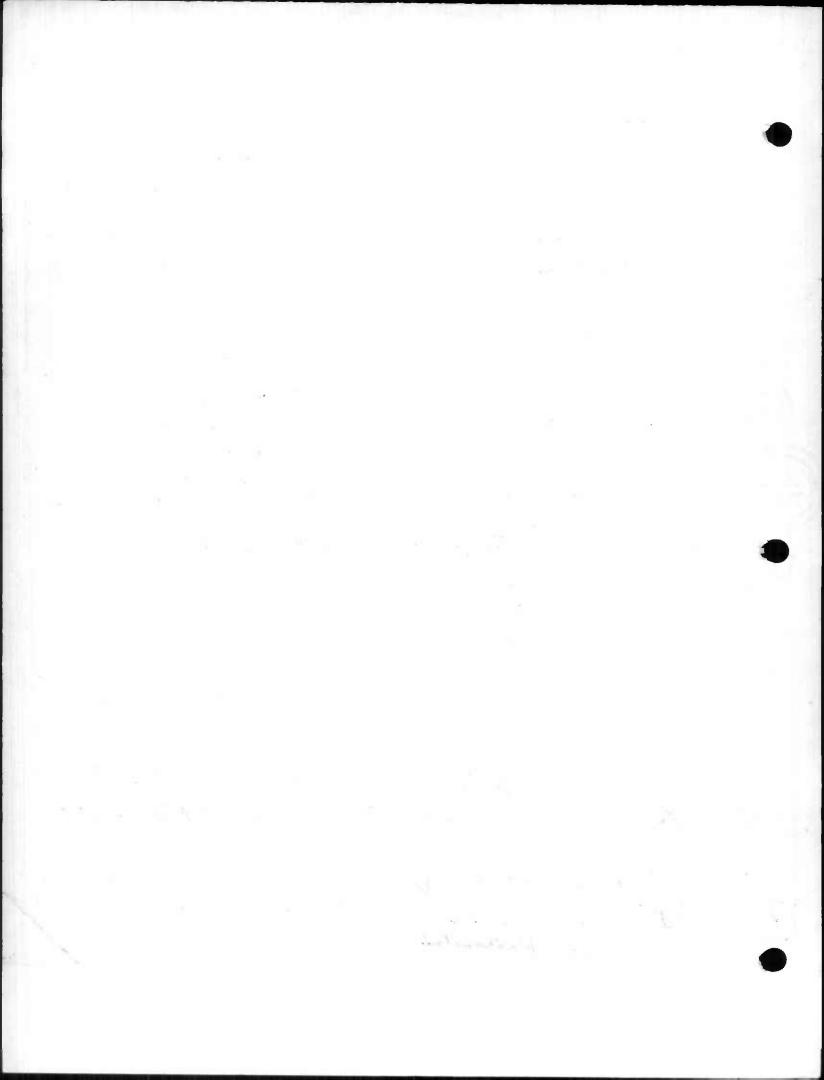
| | 1 - REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO |). | | | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------|-----------------------------------|---------------------------------------------------------------|--------------------------------------------------------------|------------------|-----------|----------------------------------------------------------------------------|----------|--|
| | 1. DECEDENT'S NAME (First, Middle, La | | | | | 2. DATE OF DEATH | DAY | | 3. TIME OF DEATH | | |
| | MARION ANN 4. SOCIAL SECURITY NUMBER | GIBBS | | | | | | 995 | 4:01 | Рм | |
| | 085-36-3390 | 1 □ M 2 💢 F 48 | (In yrs. last birthday) YRS. | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) July 07, | 1947 Q | Country) | LACE (State or Foreigns, NY | In | |
| k | 9a. FACILITY NAME (If not institution, gi | | | | OR LOCATION OF DI | | 9c. COUNT | | | | |
| 5 | Fort Washington | medical Center | | Fort W | ashingto | 1 | Princ | e Go | eorges | | |
| DIRECTOR | Maryland Prin | ce Georges | Fort | Washin | gton | | | | IOd. INSIDE CITY LIMITS? | , | |
| FUNERAL | 10e. STREET AND NUMBER | | | 10 | f. ZIP CODE | | 10g. CITIZE | N OF WH | IAT COUNTRY? | | |
| | 11304 Trafalgar | | | | 20744 | UNITED | | | | | |
| | 1 Never Merried 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If yes, sp | CENDENT OF HISPAT Hecity Cuban, Maxica B 2 X NO Specifi | NIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | s or No— 1 | | - American Indian, white, etc. Black | | |
| ם כ | 15. DECEDENT'S E (Specify only highest gr | DUCATION ade completed) | (Give kind of | USUAL OCCUPATION | ON ost of working | 16b. KIND OF BU | SINESS/INDUS | STRY | | | |
| COMPLEIED | Elementary/Secondary (0-t2) | College (1-4 or 5+) | life. Do NOT u | se retired.) | | | _ | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | HOUSEW | LFE | 18 MOTHER'S NA | PRIVAT ME (First, Middle, Malder | _ | | | | |
| 1 | | EDWARD TINDAL | | | ELEASE | | Surname) | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | Route Number, City or Tox | vn, State, Zip C | ode) | | | |
| | ROBERT GIBBS | | 172-12 | 2 133 A | ve., Jan | naca, NY | 11434 | | | | |
| | 20a. METHOD OF DISPOSITION XX Buriet 2 Cremetion 3 R | emoval from State 20t | PLACE AND DATE | OF DISPOSITION (Na ther place) | ama of | | CATION — CH | | | | |
| | 4 ☐ Donation 5 ☐ Other (Specify) | LICENSEE) | NCOLN ME | | CEMETERY NO ADDRESS OF FA | 8/18 Sui | tland, | Md. | | | |
| 1 | · Alan 1 | Chan (k | M859 | ALEXA | NDER S. I | POPE FUNER | | | | | |
| | 23. PART I. Enter the diseases, or head fallow | TORY THE | | 12617 | Penn. AVe | ., S.E. W | DC 200 | 20 | | | |
| CERTIFICATION | Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C | CONSEDUENCE O | F): | ustic ce | reha-Ca | edivo Lisea | scale | | | |
| | PART II. Other significant condit Cours Shot Would Ley 12 rows DID TOBACCO USE CON | nd, howelspil | e, Post | 20 yrs, | partial | PERFO | RMED? | C | VERE AUTOPSY FINDS WAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE DF DEA | | OTTELNIAN | 1 KA | | J | | | |
| | 1 X YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | etlent 3 XDOA | OTHER: 4 I Nursing Hom | a 5 🗆 Residence | 6 Other (Specify) | | | | | |
| | 27. MANNER OF DEATH 124 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Moeth Day Year) SEPT 1975 | 28b. TIM | URY WO | VES 2 XXID | N/A SHO | | | NG OUT GAR | 8AG | |
| | 3 Suicide 8 Could not to datermined | | NA. | PARTMENT I | | 28t. LOCATION (Street City or Town, States JAMAICA, N. | N-A- | Rural Rou | ite Number, | | |
| COMPLE | | YSICIAN: To the best of my know | | | | | | ause(s) s | and manner as state | d. | |
| N N | 296. SIGNATURE AND TITLE OF CERTIF | Palair | M | | 29c, LICENSE NUN D21230 | IBER | 29d. DATE S | IGNED (A | fonth, pay, Year) | 200 | |
| ٥ | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez, M.D. 5009 Rayburn Court, Camp Springs, Md. 20748 | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | ATIPIE | | | | | | | \dashv | |

AUG 24 1995

Maria de la companya
20

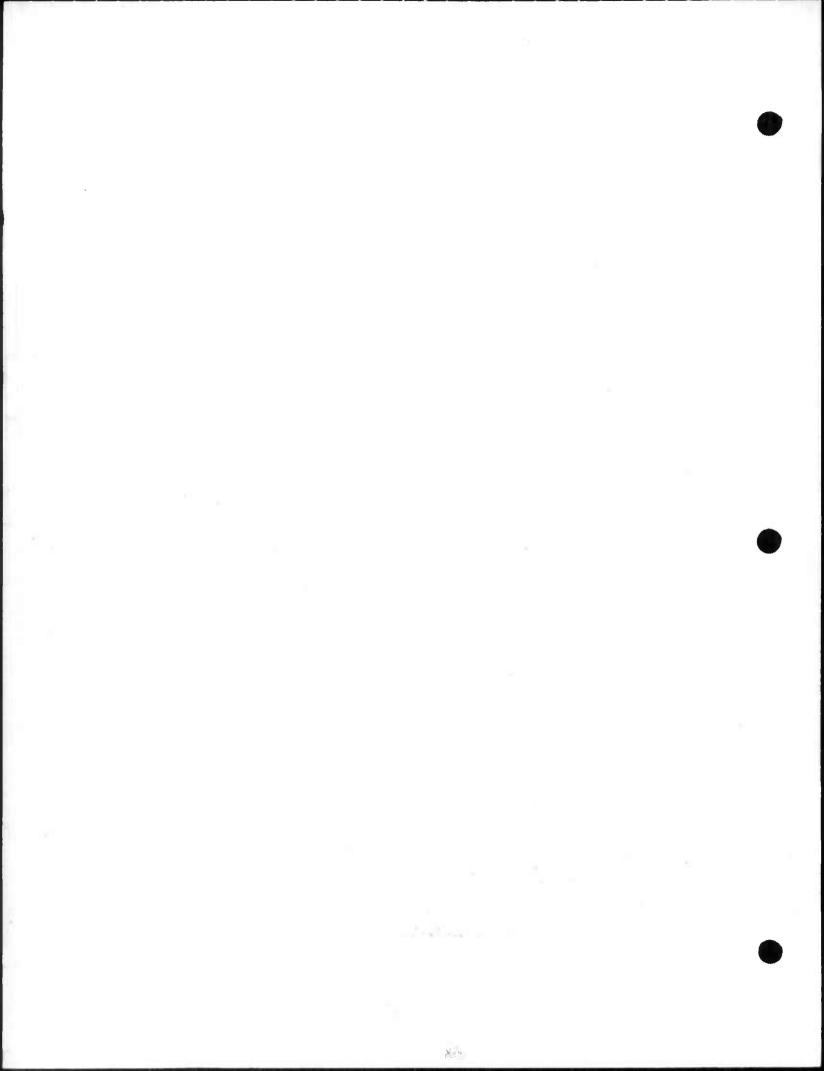
| HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with the hours after death, Page 6 may be retained by the hospital or attending physician. | FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | within 72 hours after death with the State Dept. of Neatth and Mental Hygiene prior to bunal, cremation, or removal. | TANT: It item 28 is marked, or item 20 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| | | be filed within 72 hours after death with th | IMPORTANT: If item 28 is marked, o |

| 1 - FOR STATE REGISTRAR | | STATE OF MA | | | TMENT OF | | MENTAL HYGIEN | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------|------------------------------------------|------------------------------------------------------|-------------------------------|------------------------------------------------|-----------|----------------------------|---------------------------------------------------------------------------|-------|
| t. DECEDENT'S NAME (FI/S MICHAEL | t, Middle, Last) David | GF | REEN | | | | 2. DATE OF DEATH MONTH AUGUST | 13 J | 1995 | 3. TIME OF DEATH | Pa |
| 4. SOCIAL SECURITY NUM unknown | | SEX | 3. AGE (In yrs. In | yrs. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4/14/64 | | 6. SIRTH Countr MD • | IPLACE (State or Fore ry) | ilgn |
| 9a. FACILITY NAME (II not I | | | TAL | | 96. CITY, TOWN CHEVI | OR LOCATION OF D | EATH | | INCE | GEORGE | S |
| RESIDENCE OF DE 10s. STATE | tob. COUNTY | | | t0c. CIT | Y, TOWN OR LOC | ATION | | | | tod. INSIDE CITY | |
| | P.G | • | | For | estvi | lle or, zip cope | | 140: 007 | | 1 X YES 2 □ N | 0 |
| 100. STREET AND NUMBER 6535 Hill 11. MARITAL STATUS | | • | | | | 20747 | | | | States | 5 |
| 3 Widowed 4 Div | Married | FYES, OIVE WA | YES 2 | RMEO NO | If yes, | | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | e or No- | 14. RACI Bleck BIa | E — American Indian k, White, atc. | i, |
| | CEDENT'S EDUCAT hy highest grade cor 0-12) | | - A | ECEDENT'S Give kind of vie. Do NOT us | USUAL OCCUPA work done during in the retired.) | TION nost of working | 16b. KIND OF BU | | OUSTRY | | |
| 17. FATHER'S NAME (First, I | | | 1 2 | OXEL | | 16. MOTHER'S N | AME (First, Middle, Maide | | | | |
| POTOMON 1 | | | | | | | hy Owens | | | | |
| P Ann Green | | ev | -1 | | | | Route Number, City or To | | | | |
| 20a. METHOD OF DISPOSI t [-] Burlal 2 Cremati | TION | | | AND DATE | of disposition (| Name of | | OCATION - | - City or To | | |
| 23. PART I. Enter the | diseases, or con | Faw | caused the d | | 3910 | Silver | Ch as cardiac or real | . Su | itl. | | |
| | | | | | | | | | | | |
| If sny, leading to immonause. Enter UNDERLY CAUSE (Disease or International Int | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| PART II. Other signific | | | | | | | 1 YES | ORMED? | 248 | b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CA OF DEATH? | AUSE |
| DID TOBACCO | | BUTE TO CAL | | | TH (Check only or | | N 🗆] | | | | |
| EXAMINER? 1 X YES 2 NO | | NOSPITAL: | ER/Outpetlant | 3 🗆 DOA | OTHER: 4 Nursing H | ome 5 🗆 Realdence | 5 Other (Specify) | | | | |
| 2 Accident | Pending Investigation | 28a. DATE OF 1 | 195 | 286. T/N | YEY | NJURY AT NORK? YES 2 NO | 28d. DESCRIBE HOW 28f. LOCATION Street | ect | CCURED 1 | of | |
| 3 Sulcide 8 Homicide | Could not be determined | building, a | Mc. (Specify) | REI | 57 | | 2355 B | KD | bun | ell Dr. | |
| Carried Control | | - | | | | | e to the cause(e) end m | | | (e) and menner as st | eted. |
| 0 70 | E OF CERTIFIER | Lorke | M | 0 | | O.C.M. | E | JA€ | JGUS | T 14, 19 | |
| 31. DATE FILED (Month, De | PONL | COMPLETED CAUS | SEL P | | enn S | treet, I | Baltimore | e, Ma | aryl | and 212 | 01 |
| AUG 23 | | 72 REGISTRAF | elected | dell | | | | | | | |



FOR STATE REGISTRAR

| | | nedistrian | | UE | ED HIER | CAIL | JE DEA | | REG. NO | | | | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF OEATH | | | 3. TIME OF DEATH | |
| | | Mary M | cLean G | annon | | | | | 8 14 | | YEAR | 6.10 3 4 | |
| | | 4. SOCIAL SECURITY NUMBER | 1 | AGE (In yrs. less | f blethelast | IF UNDER 1 YE | 40 05 1000 | 70 04 1m0 | 7. DATE OF BIRTH | 19 | | 6:10 A M | |
| | | | | | | MONTHS DA | | R 24 HRS. | (Month, Day, Year) | | Country | | |
| 9 | | 051 40 0192 | 1 M 2 F | 97 | YRS. | | | | Jan. 1, 18 | 398 | New | York | |
| pinous | | Se. FACILITY NAME (If not institution, give | street and number) | | | 96. CITY, TO | WN OR LOCAT | ION OF DE | EATH | 9c. COUR | NTY OF OI | EATH | |
| 60 | E E | Villa Rosa Nurs | ng Home | | 1 | Mito | hellv | 1110 | | Dri | 200 | George's | |
| 5, | I E I | RESIDENCE OF DECEDENT | ang mome | | | 111.00 | .IICIIV. | TITE | | 111 | nce | George S | |
| SS. | DIRECTOR | 10a, STATE 10b, COUNT | Υ | | 10c. CITY. | TOWN OR L | DCATION | | | | | 10d, INSIDE CITY | |
| Pages | 뜻 | New Jersev Alt | antic | | M. | | | | | LIMITS? | | | |
| permit. | | 10a. STREET AND NUMBER | ancic | | Ma | argate | | | | | | 1 YES 2 NO | |
| | ERAL | 7 | | | | | 10f. ZIP CO | DE | | 10g. CITU | ZEN OF W | HAT COUNTRY? | |
|). Insid | | P.O. Box 337 | | | | | 08 | 3402 | | U: | nite | d States | |
| 215-0020 attending physician. se as the burial-transit | FUN | 11. MARITAL STATUS | 12. WAS DECEDENT E | VER IN U.S. ARI | MEO | 13. WAS | DECENOENT | OF HISPAN | NIC ORIGIN? (Specify Yes | | | | |
| Days buri | 4 | 1 Never Merried 2 Merried | FORCES? 1 I | YES TON | 10 | If yes | , specify Cub | en, Mexica | n, Puerto Rican, atc.) | | Black | , White, etc. | |
| 21215-0020 al or attending physic for use as the burial | B | 3xx Widowed 4 ☐ Divorced | IF 163, GIVE WAY | ON DATES | NO If yes, specify Cuben, Mexican, Puerto Rican, stc.) I □ YES 2 ☒ NO Specify: No White | | | | | | | White | |
| 1215 r attend use as | 8 | 15. DECEDENT'S EDL | CATION | 10- 05 | OFFICE AND | | | | | | | *************************************** | |
| 3 | | (Specify only highest grade | | (G/ | OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refined.) | | | | | | | | |
| के हैं | | Elementary/Secondary (0-12) | College (1-4 or 5 +) | 170. | DO NOT USE | retired.) | | | | | | | |
| See of the see of | ₹ | 12 | | | Homen | naker | | | Own Hon | Own Home | | | |
| AND the hospital detached to once. | COMP | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MO | THER'S NA | ME (First, Middle, Melden | Surname) | | | |
| 4 8 4 X | Ш | Daniel Mc Lean | | | | | | | Horgan | | | | |
| TAR stained to should | 0 | 19e. INFORMANT'S NAME (Type/Print) | | 100 | | 1000000 101 | | | | | | | |
| MARYLAND retained by the hospit should be detached notified at once. | 121 | A CANAL AND DESCRIPTION OF THE PARTY OF THE | | | | | | | Route Number, City or Town | | | | |
| ay be | | Edmond J. Gannor | 1 | P | '.O. E | 33 33 33 33 35 35 35 35 35 35 35 35 35 3 | / Mar | gate | New Jersey | 0840 | J2 | | |
| 6 may ctor, pag | 1 1 | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremellon 3x Rem | normi fonom Ctata | 20b. PLACEA | NODATEOF | FOISPOSITIO | N (Name of | | | CATION (| City or To | wn, State | |
| MOR age 6 ma director, p | 1 1 | 4 Donation 5 Other (Specify) | TOTAL TOTAL STATE | Mt.S | t.St. Mary Cemetery 8/17/95 Flushing New York | | | | | | | | |
| BALTIMORE, after death. Page 6 may be by the funeral director, page noval. cal examiner must be | 1 1 | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | 22. NAM | E ANO ADDRI | ESS OF FA | CILITY | | | | |
| ALTIN death. Pag tuneral di i. examiner | 1 1 | ND 0 -1 0 | 3 | | | Rob | ert E. | . Eva | ns Funeral | Home | e, P | .A. | |
| SA Ser de Charle fu de Charle f | | Bount C | . CITIA | is [| 200 | 160 | 00 Anı | napol | is Rd. Bow | rie Me | d. 20 | 0715 | |
| Ca y | | 23. PART i. Enter the diseasea, or | complications that c | aused the de | ath. Do no | ot enter the | mode of dy | ing, suc | h aa cardiac or reapi | ratory arr | est. | Approximate | |
| hours ed in to or rei | 1 1 | anock, or neart failure. | Liat only one cause | on each line. | | | | | | | | interval Between | |
| | 1 1 | iMMEDIATE CAUSE (Final disease or condition | 141. | | 0. | 1:0 | 1.1 | - | of Disa | | | Onset and Death | |
| od within 24 ompletely fill cremation. | | resulting in death) | · MINE | 1070 | Leri | OTIC | 5 | Con | y DISA | Low | | 6/92 | |
| Ne cree | 1 1 | | OUE TO (OF | R AS A CONSEC | UENCE OF) | : / | | | \ | | | 10/12 | |
| executed and con o burial, | z | | , Perhe | Cir | 111 | r | no | m | 101 | | | Cla- | |
| | 일 | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 10/42 | |
| ta in | I ₹ I | cause. Enter UNDERLYING | | | | | | | | | | , | |
| certificate ding physi lygiene pr | H | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| O Signature | E | resulting in death) LAST | minuted events | | | | | | | | | i I | |
| D. E S - 8 | CERTIFICATION | | d, | - | | | | | | | | | |
| . 24 3 | 1 11 | PART ii. Other aignificant condition | a contributing to de | ath but not re | esuiting in | the under | vina ceuse | alven in | Part i. 24e. WAS AN | ALITOREY | 0.00 | WEST ALTERSAL FRANCES | |
| T # 5 5 - | EDICAL | | norti Ve | The state of the s | 2 | 1 -1 | Ama canada | given in | PERFOR | | 240. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| uires that signed by Health and | ă | regen | noun or | | 20 | 100 | | 71C | 1 YES 2 | NO | | OF DEATH? | |
| quires auries a signa Healt | M | Demer | tion | | | | | | | | | 1 YES 2 NO | |
| law requires been so bept. of the 23 show | | DID TOBACCO USE CONT | RIBUTE TO CAUS | SE OF DEAT | TH YES | . □ NO | A UNG | FRTAIN | <u>_</u> | | | | |
| | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | (Check only | | CENTAII | 1 0 1 | | | | |
| | 힐 | EXAMINER? | HOSPITAL: | | - | OTHER: | one, | | | | | | |
| S S S S | \ X S | 1 TES 2 XALO | 1 Inpatient 2 E | | □ DOA 4 | Nursing | Home 5 🗆 R | esidence | 6 Other (Specify) | | | | |
| This can with the def. | 표 | 27. MANNER OF DEATH | 28a. DATE OF IN. (Month, Day, | JURY Year) | 28b. TIME INJUI | | INJURY AT WORK? | | 28d. DEŞCRIBE NOW II | JURY OCC | URED | | |
| NG PHYS feer this coath with marked | BY | 1 Natural 5 Pending 2 Accident Investigation | | | | | YES 2 | □ NO | | | | | |
| WDING WDING After death | | 1 Sulpide | 28e. PLACE OF II | VJURY — Al hor | ne, ferm, str | reet, factory, | office | | 28f. LOCATION (Street a | and Number | or Rumi B | outs Mumber | |
| OR ATTENDING OR ATTENDING DIRECTOR: After hours after death item 28 is ma | 8 | 4 Homicide determined | building, etc. | . (Specify) | | , | | | City or Town, State) | no monitori | or riorer ric | AUTO TRUTTUON, | |
| OR ATTEN OR ATTEN DIRECTOR: hours after tom 28 i | <u></u> | | | | | | | | | | | | |
| L OR A L DIRECT Phours | 립 | 29e. CERTIFIER 1 CERTIFYING PNYS | knowledge, des | nth occurred | at the time, | date end place | , end due | to the cause(e) end man | ner ee state | id. | | | |
| THE HOSPITAL THE FUNERAL filed within 72 | COMPLET | | | | | | | lime, date end piece, en | | | end menner ea stated. | | |
| MITH WITH | 8 | 29b. SIGNATURE NO TITLE OF CONTINE | | | | - | | | | | | | |
| 분 분 를 등 | #d | SIGNATURE OF CONTINE | CA | | | 29c. LIC | ENSE NUN | IBER | 29d, DATE | SIGNEO | (Month, Day, Year) | | |
| TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT: I | 5 | 1 +1 (71) | - 1 | | | $\perp D$ | 70 | 108 | > 7 | 5/1 | 7/7/ | | |
| | | 30 NAME AND ADDRESS OF PERSON WH | COMPLETED CAUSE | OF DEATH (ITEM | 27) (Type, P | Print) | 1 . 1 | 100 | Carrie 2 9 | 5. | 4 | | |
| 3) | | KAKESHA | MD 14 | 1300 | OGA | LLA | NI | UXLN / | SOV | VIF | MD20715 | | |
| | | 31. DATE FILED (Month, Day, Year) | M. REGISTRAD'S | | | | | | | | | ,, | |
| | | AUG 25 1995 | SIGNATURE | all | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netitled at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | | | | | | TOPTI | | DEA | 111 | HEG. NO | • | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------|----------------------------------------|------------------------------------|---------------|------------------------------------------|--------------------------------------------------|--------------------|-------------|----------------------------------------|-------------------|--------------------|---------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, | | | | | | | | | 2. DATE OF DEATH MONTH DA | AY. | YEAR | 3. TIME OF DEATH | |
| | | | | R. Gio: | | | | | | August 17. | 199 | | 11:50 P M | |
| | 4. SOCIAL SECURITY NUMB | | 5. SEX | 6. AGE (In yrs. Is | | MONTHS. | R 1 YEAR | HOURS | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 6. BIRTH Countr | PLACE (State or Foreign | |
| | 082 03 8560 | | 1 🔀 M 2 🗌 F | 82 | YRS. | | | | | July 10,19 | 13 | Cici | lly, Italy | |
| ~ | 9e. FACILITY NAME (If not in: | | | | | 9b. CIT | Y, TOWN | OR LOCATI | ON OF DE | ATH | 9c. COU | NTY OF D | EATH | |
| DIRECTOR | Crofton Co | nvale | scent Cer | nter | | Cr | ofto | n | | | Ann | e Arı | inde1 | |
| <u>u</u> | 10a. STATE | 10b. COUNTY | , | | 10c. CIT | Y, TOWN | OR LOCA | TION | | | | | 10d, INSIDE CITY | |
| 듬 | Maryland | Anne | Arundel | | Ga | ambr | i11e | | | | | | LIMITS? 1 YES 2 X NO | |
| | 10e. STREET AND NUMBER | | | | | | | f. ZIP COD | E | | 10a. CIT | IZEN OF W | HAT COUNTRY? | |
| FUNERAL | 2207 Huntfie | 1d Cor | ırt | | | | | 21 | 054 | | | USA | | |
| 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | 13. | WAS DEC | CENDENT (| OF HISPAN | IC ORIGIN? (Specify Yes | or No— | 14. RACE | - American Indian. | |
| | 1 Never Married 2 | | FORCES? 1 IF YES, GIVE W | ☐ YES 2 ☑ WAR OR DATES | NO | | It yes, sp | ecify Cube | ın, Mexicai | n, Puerto Rican, etc.) | | Black Specif | , White, etc. | |
| ĕ | 3 Widowed 4 Divor | | | | | | | 23 | | | | White | | |
| | 15. DECI (Specify only | DENT'S EDUC highest grade | CATION completed) | (0 | ECEDENT'S | work done | during me | ON ost of world | na | 16b. KIND OF BUS | BUSINESS/INDUSTRY | | | |
| ١٣ | Elementary/Secondary (0- | 12) | College (1-4 or 5 d | +) life | e. Do NOT us | | tired.) | | | | | | | |
| COMPLETED | 6 | | | | Homei | nake | r | | | | n Hor | ne | | |
| | 17. FATHER'S NAME (First, Mi | | | | | 18. MOTHER'S NAME (First, Middle, Meiden | | | | | | | | |
| BE | Frank R | landazz | 20 | | - 111 | | | | | ine Patern | | | | |
| 2 | | | | | | | | | | loute Number, City or Town | | | | |
| | Tony Gioia | | | | | | | | urt (| Gambrills, | | | | |
| | 1 N Buriel 2 Cremation | n 3 🗆 Remo | oval from State | 20b. PLACE cemetery. cr Fort | ematory or of | OF DISPOS ther place) | SITION (N | ame of | 0 0 | | | City or To | | |
| | 4 Donation 5 Other | | FNSFF | Fort | Linco | | | tery | | | ntwoo | od, M | aryland | |
| - 1 | | | | | | | | | | ins Funeral | Hon | D P | Δ | |
| -18 | tober | * E. | Evans; | Pres | 4 | 1 | 1600 | O Ant | ano l | ic Rd Roy | ria N | (4) | 0715 | |
| ı | 23. PART I. Enter the dis shock, or he | seases, or c art fallure. L | omplications that List only one cau | t caused the dese on each lin- | eath. Do n | ot enter | r the mo | de of dy | ing, such | ss cerdisc or respi | ratory an | rest, | Approximate Interval Between | |
| | IMMEDIATE CAUSE (Final disease or condition) Onset and Daath | | | | | | | | | | | | | |
| | resulting in death) | → , | ul | green | de | NIS | cas | 1 | <u> </u> | Dely de | elea | _ | | |
| | | | DUE TO | TOR AS A CONSE | OUENCE OF | 7:// | . , | 01 | / | 7. 100 | / | | | |
| CERTIFICATION | Sequentially liet condition | | DUE TO | 10 NG | aro | 1 10 | 0 6 | ag- | U | succepa | me | Dry. | | |
| Ž I | if any, leading to immed cause. Enter UNDERLY!! | | On | int. | William St. | | | | | | | | | |
| | CAUSE (Disease or Injur that initiated events | у 🥻 " | DUE TO | (OR AS A CONSE | OUENCE OF | j: | | | | | | | - | |
| | resulting in death) LAST | ٠. | E. | | | | | | | | | | | |
| 5 | | - | | | | | | | | | | | | |
| ₫ | PART II. Other significer | t conditions | contributing to | death but not | reculting I | n the ur | nderlyin | g ceuse (| given in i | Part I. 24a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | |
| 5 II | | | | | | | | | | YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? | |
| Ž. | | | | | | | | | | +/ | | | 1 - YES 2 - NO | |
| ž I | DID TOBACCO US | | RIBUTE TO CA | | | | | UNC | ERTAIN | 11/2 | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S. WAS CASE REFERRED TO MEDICAL 28. WAS CASE REFERRED TO MEDICAL 29. PLACE OF DEATH (Check only one) EXAMBLERY 1 YES 2 100 27. MANNER OF DEATH 280. DATE OF INJURY 27. MANNER OF DEATH 280. DATE OF INJURY 280. INJURY AT 280. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | | | |
| 2 | 1 Typesteri 2 ER/Outpetient 3 DOA | | | | | | ning Hom | _ | sidence i | § ☐ Other (Specify) | | | | |
| | 17. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) | | | | | UNY | | RIC? | | 28d. DESCRIBE HOW IN | DURY OCC | CURED | | |
| ፳ 📗 | 2 Accident to | ome, farm, s | | | res 2 | NO | | | | | | | | |
| 3 I | 3 Suicide 6 C | ome, term, s | treet, tech | tory, offic | | | 28f. LOCATION (Street at City or Town, State) | nd Number | or Runs! As | sum Numbec | | | | |
| 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner so stated. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 3 | 296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Most), Dev. Year) | | | | | | | | | | | | | |
| u II | | | | | | | | | | | | | | |
| | 1,00 | nac | 4 67 | out | no | n | | 0 | 188 | 20 | • | 8/18 | 158 | |
| - 1 | M. HAME AND ODRESS OF | | | | | | | | | | | | | |
| | Ronald Sro | ka M.D | . 3 Vill | age Gre | en Cr | ofto | on Me | d. 21 | 114 | | | | | |
| | 31. DATE FILED (Month, Day, Y | | 2 REGISTRA | RIS SIGNATORE | 41 | | | | | | | | | |
| | AUG 25 | 1995 | Juna mas | | | | | | | | | | | |
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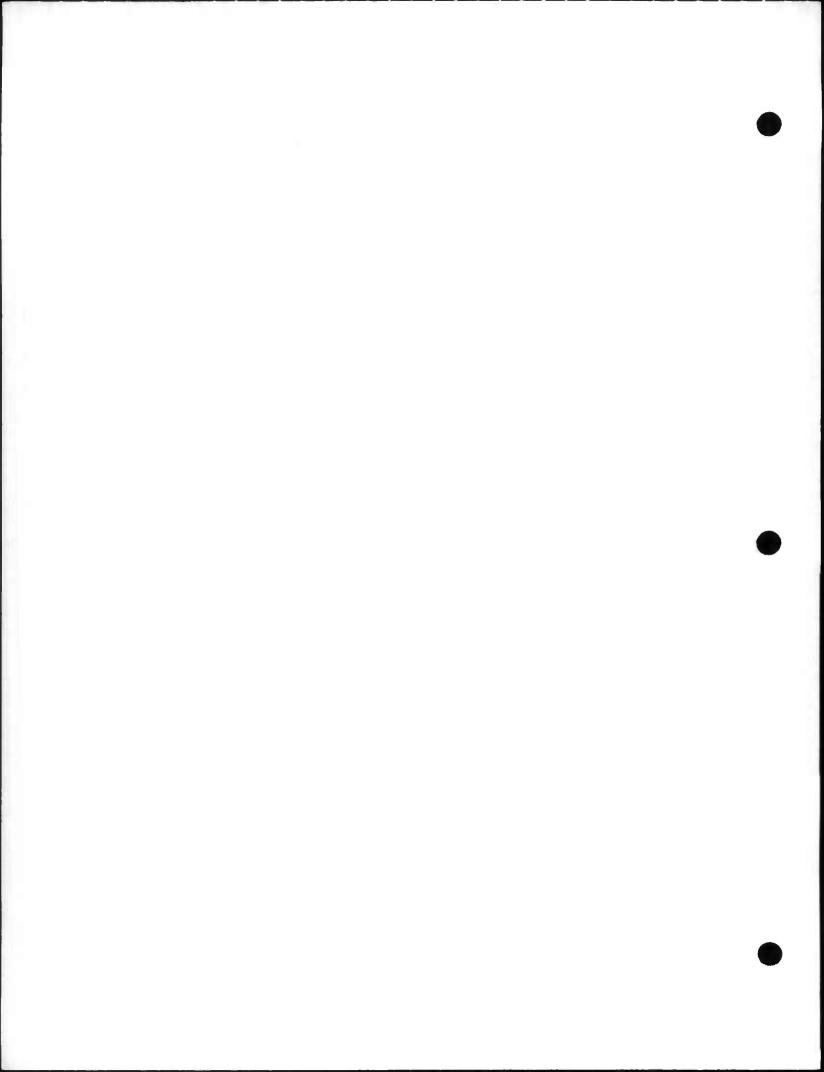
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| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. PORTANT: If Ilem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

BEG NO

| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | - | | 2. DATE OF | DEATN | | T | 3. TIME OF DEATH | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------|-------------------|-------------------------------|------------------------------|---------------------------|----------------------|-----------------------|-----------|-----------------|------------|--------------------|------------------|-------------------------------------------|--|
| | Mary C. C | Gonzale | 28 | | | | | | | Aug. | DA | 995 | YEAR | 6:35 A M | |
| | 4. SOCIAL SECURITY NUMB | | 5. SEX | 6. AGE (In yrs. Is | ast birthday) | JE LINDE | R 1 YEAR | IF UNDER | 24 MRS | 7. DATE OF E | _ | . 999 | | PLACE (State or Foreign | |
| | 577-20-8439 | | 1 □ M 2 🗓 F | 88 | YRS. | MONTHS | DAYE | HOURS | MIN. | (Month, De | ly, Year) | | Country | 1) | |
| | 9e. FACILITY NAME (If not in | | treet and number) | 00 | | ab CIT | V TOWAL | OR LOCATI | ON OF DE | Jan. 8 | 3, 19 | | | ginia | |
| œ | 5917 Mentan | | , | | | | | | | EATH | | | NTY OF DE | | |
| DIRECTOR | RESIDENCE OF DEC | | et | | New Carrollton | | | | | Prince Geor | | | George's | | |
| E C | 10e. STATE | 10b. COUNTY | , | | 10c. CITY, TOWN OR LOCATION | | | | | | | 10d, INSIDE CITY | | | |
| 늄 | Maryland | Princ | e George | ts | Hva | attsv | 71114 | 3 | | | | | | LIMITS? 1 YES 2 NO | |
| | 10e. STREET AND NUMBER | | | | 1) | | | . ZIP COD | E | | | 10a, CIT | | HAT COUNTRY? | |
| FUNERAL | 5808 33rd P | 1ace | | | | | | 20782 |) | | 1.5 | | | States | |
| 3 | 11. MARITAL STATUS | Ideo | 12. WAS DECEDER | IT EVER IN U.S. A | RMED | 13 | | | | NIC ORIGIN? (S | anathi Maa | | | | |
| 正 | 1 Never Married 2 | | FORCES? | YES 2 X | NO | | If yes, sp | ecify Cube | m, Mexice | n, Puerto Ricer | n, etc.) | Black, White, atc. | | | |
| BY | 3 Widowed 4 Divo | rced | | AN ON DATES | | | 1 1 153 | 2 K) NO | Specin | y: | | | SpecHy: White | | |
| | | EDENT'S EDUC | | 16e. D | ECEDENT'S | USUAL O | CCUPATIO | ON | | 16b. KIN | D OF BUS | INESS/IN | DUSTRY | WILLE | |
| ᄪ | Elementary/Secondary (0 | highest grade (-12) | College (1-4 or 8 | | Oive kind of le. Do NOT u | work done se retired.) | during mo | ast of worki | ng | | | | | - 3 | |
| P | 7 | | | Te | 1epho | ne C |)pera | tor | | Te1 | epho | ne C | ompai | nv | |
| ő | 17. FATNER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) | | | | | | | | | | | | Ompar | , | |
| | | | | | | | ecca | Wilt | | | | | | | |
| | | | | | | | Code) | | | | | | | | |
| 2 | Evelyn Lean | narda | | | | | | | | | | | | 20784 | |
| | 20e. METNOD OF DISPOSITI | | | | AND DATE | | | | | | | | City or Tow | | |
| | 1 Sp Burlel 2 Cremation 4 Donation 5 Other | n 3 🗆 Remo (Specify) | oval from State | comptent of | manatan, as a | shor stoop! | 1 | | Q / 1 | | ľ | | | Maryland | |
| | 21. SIONATURE OF FUNERAL | SERVICE 150 | ENGER / | | Dine | 22. | NAME AF | ID ADDRE | SS OF FA | CILITY | | | | laryrand | |
| | • | 1 | 1/m | 6.00 | | | | | | Funera | | - | | | |
| | | 1 | 8 10 | WH - | 2 | 3 | 401 | B1ad | ensb | urg Rd | ., B | rent | wood, | MD 20722 | |
| | 23. PART i. Enter the di ahock, or hi | senses or c | complications the | t caused the duse on each lin | eath. Do r e. | not enter | r tha mo | da of dy | ing, auci | h aa cardiac | or reapir | etory an | reat, | Approximata interval Between | |
| | IMMEDIATE CAUSE (Fin | ai | () | | 0 | | | | | | | | | Onset and Death | |
| | disease or condition resulting in death) a. Comiss of Colors 3 month | | | | | | | | | | | 3 months | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| S | Sequentially list conditi | pna. |) | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | If any, leading to immediates. Enter UNDERLYI | diate | DUE 10 | (OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| 일 | CAUSE (Disease or inju- | | DUE TO | (OR AS A CONSE | OUENOE O | | | | | | | | | | |
| Ē | that initiated eventa resulting in death) LAS | 7 | 002 10 | (OH AS A CONSE | OUENCE OF | JE OF): | | | | | | | i | | |
| 與Ⅱ | | | 1 | | | | | | | | _ | | | | |
| ايد | PART ii. Other aignifice | nt condition | contributing to | death but not | reaulting | in the ur | nderlying | cause (| lven in | Part i. 24s | . WAS AN A | | 24b. | WERE AUTOPSY FINDINGS | |
| 5 | | | | | | | | | | | PERFORM | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | | | | | | | | | _ 1 | YES 2 | NO NO | | OF DEATH? | |
| | DID TOBACCO U | SE CONTE | PIBLITE TO CA | LISE OF DEA | ATH VE | s □ 1 | NO E | r usia | EDTAIL | | | | | 1 TES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO | | IDUIL IO CA | | CE OF DEAT | | | POINC | EKIAII | 4 🗀 📗 | | | | | |
| 2 | EXAMINER? | | HOSPITAL: | | | OTHE | R: | 17252 | | | | 70 | | _ | |
| ¥∥ | 27. MANNER OF DEATN | | 1 Inpatient 2 I | | 28b. TIM | | sing Nom 26c. INJ | 3.3. | aldenca | 6 Other (Spi | | 200 | . 140 | Spice | |
| | | Pending | (Month, D | wy, Year) | | URY | WO | RK? | | 28d. DEŞCRIE | BE HOW IN | JURY OC | CURED | | |
| B | 2 Accident Investigation | | | | | | | /ES 2 [| NO | | | | | | |
| | | | | | | PETODE, TOC | tory, omc | • | | 281. LOCATION | | nd Number | or Rural Ro | oute Number, | |
| | | | | | | | | | | | | | | | |
| 29e. CERTIFIER (Check only 0 ne) 1 📉 CERTIFYINO PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner se atsted. | | | | | | | | | | | | | | | |
| 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) | | | | | | | | end manner ee stated. | | | | | | | |
| | | | | | | | | Month, Day, Year) | | | | | | | |
| | Borns Ru | سيامان | , M. | , | | | | 10 | 90 | 660 | | ▶ 0 | | N 11 (085 | |
| 2 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAU | SE OF DEATH (ITE | М 27) (Туре, | Print) | | | | | | 1 | U | - (1) | |
| | Boris (| SAX | KIN | GM | 1010 | LI F | | , 6 | 31 | DE | K | Col | wil | mi mal | |
| | 31. DATE FILED (Month, Day, 1 | (bar) | 32. REGISTRA | R'S SIGNATURE | - 1 | 1 | ~/ 0, | - 1 | - 10 | 0 00 | 1 200 | - | | 120483 | |
| | #IG 91 1 | 995 | Julia Dhu | dear Rando | Щ | | | | | | | | | (%) | |
| | | Market | 9 | | | | | | | | | | | | |

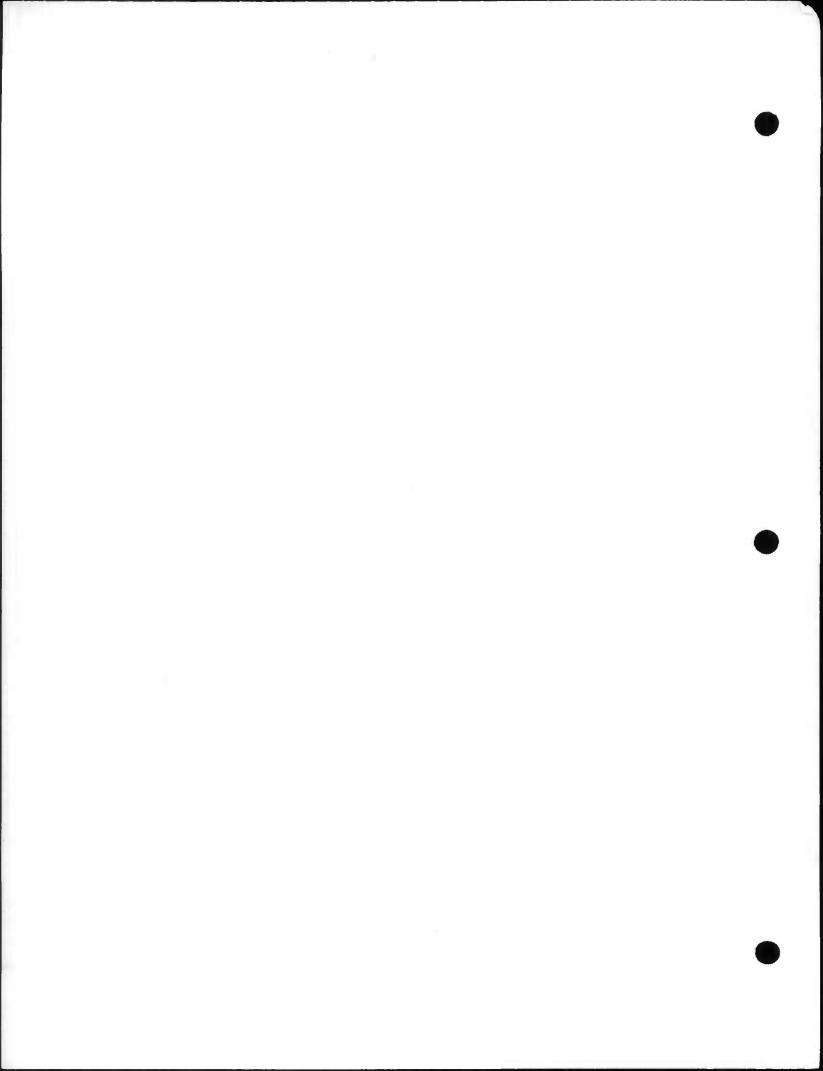


BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE OF MARYLAND REGISTRAR C | / DEPARTME | | | MENT | AL HYGIENE | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------|------------------|------------|------------------------------------------|-------------------------|----------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | DEATH | | TE OF DEATH | | 3. TIME OF DEATN | | | |
| | Mildred Catherine Grace | | | | Ju | ly 31 | 1995 | 12:40 PM | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. le | | DER 1 YEAR | IF UNDER 24 HRS. | 7. DA | TE OF BIRTN | 8. BIRTH | PLACE (State or Foreign | | | |
| | 216-10-1972 A 1 □ M 2 XF 87 | YRS. MONT | HS DAYS | HOURS MIN. | | 22, 190 | S Me | arvland | | | |
| | 9e. FACILITY NAME (If not institution, give street end number) | 96. 0 | CITY, TOWN O | R LOCATION OF D | | | 9c. COUNTY OF D | | | | |
| DIRECTOR | Meridian - The Pines | | Ea | ston | | | Tal | bot | | | |
| EC | 10e. STATE 10b. COUNTY | 10c. CITY, TOW | /N OR LOCAT | ION | | | | 10d. INSIDE CITY | | | |
| | Maryland Talbot | Sherw | boo | | | | | LIMITS? | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | ZIP CODE | | | 10g. CITIZEN OF V | VHAT COUNTRY? | | | |
| NEF | 21740 Cabin Lane | | | 21665 | | | USA | | | | |
| F | 11. MARITAL STATUS 1 Never Married Nerried PF S, GIVE WAR OR DATES 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 YES 1 YES GIVE WAR OR DATES | RMED NO | 13. WAS DEC! | ENDENT OF NISPA | ANIC ORI | GIN? (Specify Yee o | or No 14, RACE Black | - American Indian, c, White, etc. | | | |
| BY | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES | | 1 TYES | 2 XNO Speci | offy: | | Speci | " Black | | | |
| ED | 15. DECEDENT'S EDUCATION 16a. D | ECEDENT'S USUA | L OCCUPATIO | N | 1 | 6b. KIND OF BUSH | NESS/INDUSTRY | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | Give kind of work do s. Do NOT use retire | one during mos id.) | st of working | | | | | | | |
| MPI | 5 I | omestic | | | | Service | | | | | |
| S | 17. FATNER'S NAME (First, Middle, Last) | | | 18. MOTHER'S N | IAME (Firs | t, Middle, Malden Si | umame) | | | | |
| BE | Albert Honey | | | Emma | | | | | | | |
| 5 | N M N N N N N N N N N N N N N N N N N N | | | | | imber, City or Town, | | | | | |
| | | | | | | | d 21665 | | | | |
| | 1 Buriet 2 Cremation 3 Removal from State cemetery, or | AND DATE OF DISI ematory or other ple | cel | | 1 | | ATION — City or To | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | ames' C | | D ADDRESS OF F | 8/5/ | 95 She | rwood, V | D. 21665 | | | |
| - 8 | 12/11/2 | | | | | rd Fune | ral Home | | | | |
| | 23. PART I. Enter the diseases, or complications that caused this d | Z (4 | 219 0 | Malle A | CIA | 01 27 | | MD 21663 | | | |
| | anock, or neart isliure. List only one cause on each lin | 0. | | | | | | Approximats Interval Between | | | |
| I | IMMEDIATE CAUSE (Final disease or condition | CERE | 1.100 | ler a | . / | 1 | | Onset and Death | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): ARTERIOGUERATIC CARDIOVASCULAR DISEASE DUE TO (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| 7 | ARTERIOSCIENZATIC CARDINIARIULAN DISEAR | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | QUENCE OF): | 107 | Cylody | JUN 1 | - 1176 | 130 | | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| E | that initiated events resulting in death) LAST | OUENCE OF): | | | | | | | | | |
| 监 | d | | | | | | | | | | |
| AL 0 | PART II. Other significant conditions contributing to death but not | rasulting in the | underlying | cause given in | n Part i. | 24e. WAS AN AI | UTOPSY 24b. | WERE AUTOPSY FINDINGS | | | |
| 5 | ORGANIC BRAIN Sy | NONOME | | | | PERFORM 1 YES 2 9 | | AMAILABLE PRIOR TO COMPLETION DF CAUSE | | | |
| MEDIC | CARDIAC ARRHYTA | MIA | | | | 1 1 160 2 2 | 110 | OF DEATH? | | | |
| ž | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA | ATH YES | NO 🗆 | UNCERTAI | IN B | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 28. PLA EXAMINER? HOSPITAL: | CE OF DEATH (Che | | | | | | | | | |
| YSI | 1 YES 2 NO 1 Inpetient 2 ER/Outpetient | DOA 4 | | 5 Residence | 6 🗆 Ot | her (Specify) | | | | | |
| H | 27. MANNER OF DEATH 1 Netural 5 Pending 26e. DATE OF INJURY (Morth, Day, Year) | 28b. TIME OF INJURY | 26c. INJU WOF | | 28d. D | EŞCRIBE NOW INJ | URY OCCURED | | | | |
| BY | 2 Accident Investigation | M | 1 🗆 Y | ES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, term, street, i | lactory, office | | 281. LC | CATION (Street end by or Town, Stete) | d Number or Rural R | oute Number, | | | |
| E | 29e. CERTIFIER | | | | | | | | | | |
| (Check only 12 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner as stated. | | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end menner se stated. | | | | | | | | | | |
| 踞 | 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNSID (Month, Day, Year) | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE | M 070 / | | V2 | 262 | 350 | · //3 | 1195 | | | |
| | | | C.L | Q1 15 | | | (D 04 = | 63 | | | |
| | Dr. William Bremer 800 S. T 31. DATE FILED (Month, Day, Year) 32. BEGISTMAR'S SIGNATURE | albot | St. | St. M | icha | aels, M | ID 216 | 63 | | | |
| | 31. DATE FILED (Month, Day, Year) AUG - 7 1995 | dall | | | | | | | | | |
| _ | - V | | | | _ | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| TO THE HOSPITA | TO THE FUNERA be filed within 7. | IMPORTANT: I | |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------|-----------------------|-----------------------------------------------------|------------------|--------------------------------------------------|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | - | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Harry Benjamin Gibbs | | | | July 28, 1995 YEAR 10:50 a | | | | | |
| | | | UNDER 1 YEAR | IF UNDER 24 HRS. | 3. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign | | | | | |
| | 225-18-7976 1X M 2 □ F | 82 YRS. MO | NTHS DAYS | HOURS MIN. | May 3, 19 | 13 | Maryland | | | |
| | 9e. FACILITY NAME (If not institution, give street and number) | | CITY, TOWN C | OR LOCATION OF DEA | | 9c. COUNTY | | | | |
| OR | Corsica Hills Nursing Cen | ter | Centr | eville | | Queer | Annes | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100, STATE 100, COUNTY | 40.000 | OWN OR LOCAT | | | | | | | |
| E | Maryland Queen Annes | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| | 10e. STREET AND NUMBER | Cen | trevil: | | | | 1 TYES 2 NO | | | |
| RA | 314 Little Kidwell Ave. | | 100 | 21617 | | USA | OF WHAT COUNTRY? | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT E | VED IN ILS ADMED | | | 2 0200000000000000000000000000000000000 | | | | | |
| | 1 Never Married 2 Married FORCES? 1 IF YES, GIVE WAR | AER SY VINO | If yes, sp | ecify Cuben, Maxican, | C ORIGIN? (Specify Yea Puerto Rican, etc.) | | RACE — American Indian, Black, Whita, alc. | | | |
| B | 3 X Wildowed 4 Divorced | ON DATES | 1 TYES | 2 NO Specify: | | ' | Specify: Black | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USO (Give kind of work | UAL OCCUPATION | ON . | 16b. KIND OF BUS | INESS/INDUST | PY . | | | |
| <u>-</u> | Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT use re | tired.) | st or working | | | | | | |
| 를 | 8th | n Laborer | | | Farm | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | E (First, Middle, Maiden : | Sumame) | | | | |
| BE | Harry B. Gibbs | | | Unknow | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | ute Number, City or Town | | | | | |
| 7 | Jeanette Hynson | 2808 C | hurch | Hill Rd, | Centrevil: | le, Md. | 2161/ | | | |
| | 20a, METHOD OF DISPOSITION 1 🔯 Burlel 2 🗆 Cremation 3 🗆 Ramoval from State | 20b. PLACE AND DATE OF D | Discolo (Na | me of | 1 | CATION — City of | | | | |
| | 4 Donation 6 Other (Specify) | Burrisvill | | | | | lle, Md. | | | |
| | A. SIGNATURE OF PORCHAST | | Beni | nie Smith | Funeral | Service | es | | | |
| | 12/11/11 | | | | 37, Easton | | 21601 | | | |
| | 23. PART I. Enter the diseases, or complications that control shock, or heart feliure. List only one cause | pused the deeth. Do not | enter the mo | de of dying, such | as cardiac or respir | ratory arrest, | Approximata | | | |
| | IMMEDIATE CAUSE (Final | on each line. | | | | | interval Between Onsat and Deeth | | | |
| | disease or condition resulting in death) | ROKIE | | | | | | | | |
| | OUE TO (OR | AS A CONSEQUENCE OF): | | 221/2 | · - A | 1 | | | | |
| NO | Sequentially list conditions, | ONIC (| 1RI | UARY | TRACT | INF | ENTIPUS | | | |
| Ě | If any, leading to immediate cause. Enter UNDERLYING | AS A CONSEQUENCE OF): | Δ | , | | | | | | |
| | CAUSE (Disease or injury & c. | | | | | | | | | |
| RTIFICATION | that initiated events resulting in death) LAST d. DECUBTIONS M.LCERS | | | | | | | | | |
| 빙 | | | | | | | | | | |
| 4 | PART ii. Other significant conditions contributing to dea | ath but not reculting in the | he underlying | ceuse given in Pr | ert i. 24a, WAS AN / PERFORI | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| MEDIC | | | | | 1 TES 2 | 4 | COMPLETION OF CAUSE OF DEATH? | | | |
| | Utronta REMAZ | | | BINCY | | | 1 TYES 2 NO | | | |
| SICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUS | | | UNCERTAIN | | | | | | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF DEATH (C | THER: | | | | | | | |
| 2 | 1 YES 2 1 1 Inpetient 2 ER 27. MANNER OF DEATH 28s. DATE OF IN.8 | VOutpatient 3 DOA | Nursing Home | 5 🗆 Residence 6 | | | | | | |
| FF | 27. MANNER OF DEATH 28a. DATE OF INJ (Month, Day, Y | (Bar) 28b. TIME OF | WO | RK? | REG. DESCRIBE HOW IN | JURY OCCURE | 0 | | | |
| à | 2 Accident Investigation | JURY — At home, form, stree | M 1 7 | | | | | | | |
| 3 | 3 Suicide 8 Could not be determined 28e. PLACE OF IN building, etc. | (Specify) | K, TRCTORY, OFFICE | ' l' | City or Town, State) | nd Number or Ru | ral Route Number, | | | |
| 9 | 29e. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and menner as stated, | | | | | | | | | |
| MYCE. | (Check only one) MEDICAL EXAMINER: On the best of my one) | knowledge, death occurred at | the lime, data | and place, and due to | the cause(a) and meni | ner as stated. | | | | |
| 3 | 2 MEDICAL EXAMINER: On the basis of exami | THEOREM STREET, IN | iny opinion, or | | | due to the cau | se(a) and menner as stated. | | | |
| H H | 296. SIGNATURE AND TITLE OF CENTIFIER | m | | 29c, LICENSE NUMB | ER TO A TO | 29d. DATE SIG | NED (Month, Day, Year) | | | |
| 2 ∦ | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O | NE ASATU OTEN OT G | | U 550 | 148 | 0/1 | 195 | | | |
| | | / | | 199 | 0.44. | · | • | | | |
| | | O. Box 339, | centre | ville, Md | . 21617 | | | | | |
| - 11 | 31. DATE FILED (MORTH, Day, Year) AUG - 7 1995 | DI-PLOYERALLY | | | | | | | | |
| - 10 | | | | | | | | | | |

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| | | completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
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| BALTIMORE, MARYLAND 21215-0020 | fler | 4 |
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| 7 | ted with a hours after death. Page 6 may be retained by the hospital or attending physician, | E C |
| | | |

DIVISION OF VITAL RECORDS, P.O. BOX 687

| he hos | detache | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hour after death. Page 6 may be retained by the hos | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hos TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached. | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |

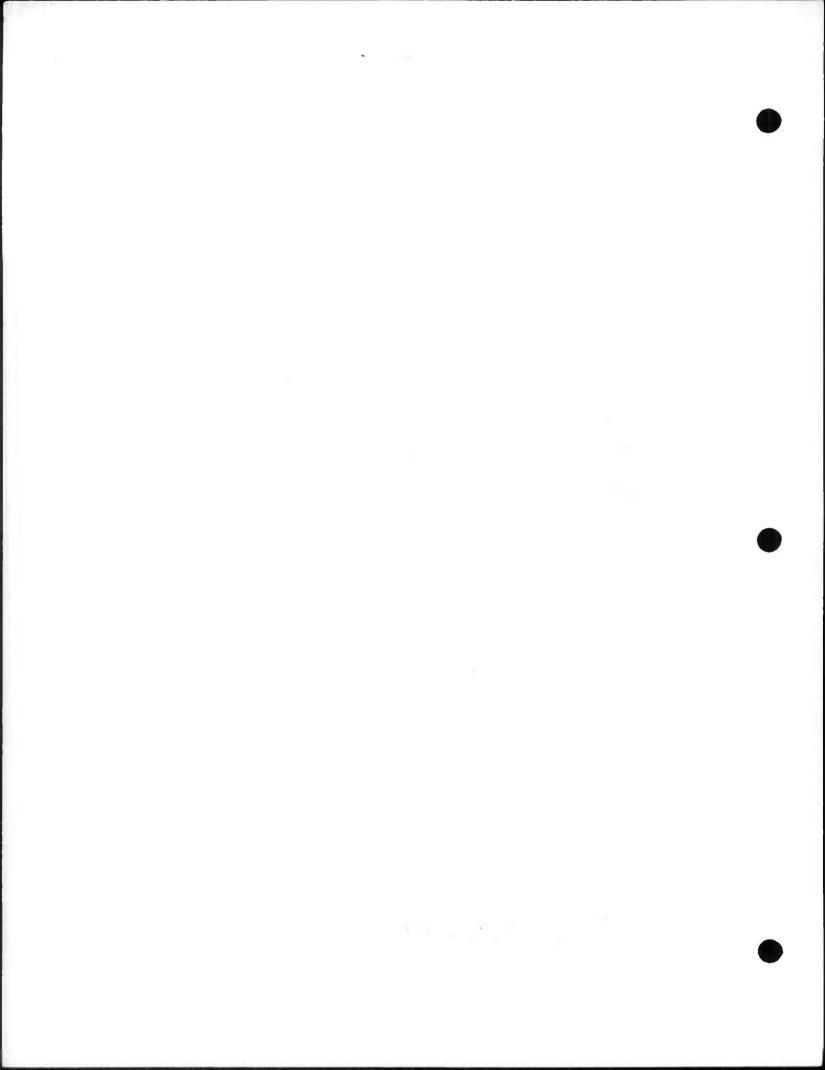
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| | FOR 1 - STATE REGISTRAR | STATE OF M | | DEPAR | | | | | | YGIENE EG. NO. | | | | |
| ij | | | | | | | | | 2. DATE OF D | EATH DAY | Y | YEAR | 3. TIME OF D | EATH |
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| | 4. SOCIAL SECURITY NUMBER | 1 000000 | 6. AGE (In yrs. les | st birthday) | | R 1 YEAR | IF UNDER | | 7. DATE OF B | IRTN | | 8. BIRTH | HPLACE (Stetu o | r Foreign |
| 7/ | 212-40-9602 | 1 □ M ZXXF | 54 | YRS. | MONTHS | DAYS | HOURS | MIN. | AUG. | 17.1 | 940 | MA | RYLANI | |
| 10 | 9s. FACILITY NAME (If not institution, give str | eet end number) | | | 9b. CITY | , TOWN C | OR LOCATIO | ON OF DE | | | | NTY OF D | | |
| HC H | MEMORIAL HOSPIT | rat. | | | | EAS | STON | | | | ф | ALB | OTT | |
| 5 | RESIDENCE OF DECEDENT | | | | | 23210 | 71011 | | | | | ALID | 01 | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | | Y, TOWN | OR LOCAT | TON | | | | | | 10d, INSIDE C | ITY |
| | MARYLAND QUEE | | | QUE: | EN A | ANNE | | | | | | 1 TES 2 | NO ON | |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | | 10g. CITI | ZEN OF V | WHAT COUNTRY | n |
| E I | 1801 STARR ROA | 4D | | | | | 21 | 657 | | | 1 | USA | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT O | F HISPAN | IC ORIGIN? (Sp | ecity Yes | or No- | 14. RACI | E — Americen I k, White, etc. | ndlen, |
| ВУ Р | 1 Never Married 2 Merried | IF YES, GIVE WA | YES 2 X | NO | | | 2 XIO | | n, Puerto Rican, | , etc.) | | Spec | Mv. | |
| | 3 Widowed 4 Divorced | | | | | | -21 | | | | - | Ī | WHITE | |
| | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 16a, DE | CEDENT'S | USUAL O | CCUPATIO | ON at of workin | 0 | 16b. KIN0 | OF BUS | INESS/IND | USTRY | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | ive kind of a | se retired.) | daring mo | or or worlding | 8 | | | | | | |
| MP | 12 | | FAC | CTOR | Y W | ORKE | ER | | TII | DEWA | TER | PUI | BLISH | ING |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTH | IER'S NAI | ME (First, Middle | , Maiden S | Surname) | | | |
| B | CLARENCE LORD | | | | | | B : | EUL | AH ADA | AMS | | | | |
| 0 | 19s. INFORMANT'S NAME (Type/Print) | | 191 | b. MAILING | ADORES | S (Street e | nd Number | or Rural R | loute Number, Ci | ity or Town, | , State, Zip | Gode) | | |
| F | W. ALLAN GAMBE | RIEL | | 1801 | ST | ARR | ROA | D, (| QUEEN | ANN | E. | MD 2 | 21657 | |
| | 20a. METHOD OF DISPOSITION | and from Chata | 20b. PLACE | ANDDATE | OF DISPOS | SITION /Na | | | OATE | _ | ATION — | | | |
| | WOODLAWN MEMORIAL PARK 8-7 EASTON, MD | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. | | | | | | | | | | | | | |
| | > | | | | - 1 3 | $N \vdash W N$ | MAI | FUNI | UDAT T | 10MF | : P | A | | |
| | | | 1 - | | | | | | | | | | | |
| | JOHN R ME | ERCER DE | 2 CE | | | 200 | S. | HARI | RISON | ST. | . E | ASTO | ON, MI | |
| | 23. PART i. Enter the diseases, or co ahock, or heart fellure. L | omplications that | caused the de | ath. Do r | | 200 | S. | HARI | RISON | ST. | . E | ASTO | Approx | |
| | 23. PART i. Enter the diseases, or co shock, or heart fellure. L IMMEDIATE CAUSE (Final | omplications that | caused the de | ath. Do r | | 200 | S. | HARI | RISON | ST. | . E | ASTO | Approx | imate |
| | 23. PART i. Enter the diseases, or co shock, or heart fellure. L | omplications that lat only one ceus | caused the de se on each line | eath. Do r | not enter | 200 | S. | HARI | RISON | ST. | . E | ASTO | Approx | imate Between |
| | PART I. Enter the diseases, or co ahock, or heart fellure. L IMMEDIATE CAUSE (Final disease or condition | omplications that lat only one ceus | caused the de | eath. Do r | not enter | 200 | S. | HARI | RISON | ST. | . E | ASTO | Approx | imate Between |
| ON | 23. PART I. Enter the diseases, or conshock, or heart fellure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | omplications that lat only one ceus | caused the de se on each line | eath. Do r | not enter | 200 | S. | HARI | RISON | ST. | . E | ASTO | Approx | imate Between |
| ATION | 23. PART I. Enter the diseases, or conshock, or heart feilure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) | omplications that lat only one ceus | caused the de se on each line | eath. Do r | not enter | 200 | S. | HARI | RISON | ST. | . E | ASTO | Approx | imate Between |
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| 0 | 23. PART I. Enter the diseases, or complete the complete the condition of the complete the compl | DUE TO IT CONTRIBUTE TO CAL HOSPITAL: | caused the de le on each line on as a consec on as a consec on as a consec deeth but not n | OUENCE OF DEATH YERE OF DEATH | in the ur | 200 the moderlying | de of dylindra | Ilven in I | Part I. 24a. | ST . or reapir | atory arr | AST(| Approx Interva Onset / - 2 - 2 - WERE AUTOPS AWALABLE PRA COMPLETION (OF DEATH? | FINDINGS OR TO OFF CAUSE |
| O | 23. PART I. Enter the diseases, or conshock, or heart feiture. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO (I | caused the de le on each line on as a consec on as a consec on as a consec deeth but not n JSE OF DEA 26. PLAC ER/Outpetient 3 | DUENCE OF DEAT | in the ur | 200 the moderlying NO only one) Resign Normal | G Cause g | Ilven in I | Part I. 24a. | WAS AN A PERFORM | WITOPSY MED? | 246 | Approx Interva Onset / - 2 - 2 - WERE AUTOPS AWALABLE PRA COMPLETION (OF DEATH? | FINDINGS OR TO OFF CAUSE |
| PHYSICIAN: MEDICAL C | 23. PART I. Enter the diseases, or complete the control of the con | DUE TO IT CONTRIBUTE TO CAL HOSPITAL: 1 Inpetient 2 □ | caused the de le on each line on as a consec on as a consec on as a consec deeth but not n JSE OF DEA 26. PLAC ER/Outpetient 3 | DUENCE OF DEAT | in the ur | 200 the moderlying NO only one) R: sing Nome 28c. INJU WO | G Cause g | ilven in i | Part I. 24a. | WAS AN A PERFORM | WITOPSY MED? | 246 | Approx Interva Onset / - 2 - 2 - WERE AUTOPS AWALABLE PRA COMPLETION (OF DEATH? | FINDINGS OR TO OFF CAUSE |
| BY PHYSICIAN: MEDICAL C | 23. PART I. Enter the diseases, or complete the control of the con | DUE TO (CONTRIBUTE TO CAL HOSPITAL: 1 Zinpatient 2 D 28e. DATE OF III 28e. PLACE OF | Caused the dele on each line OH AS A CONSECT O | DUENCE OF DEAL TIME TO DO A 28b. TIME | In the ur S | nderlying NO only one) R: sing Nome 28c. INJU 1 y | g cause g Cause g UNC UNC S = Rei | ilven in i | Part I. 24a. 1 Other (Spe 28d. DESCRIB) | WAS AN A PERFORM YES 2 | atory arr | 24b | Approxinterva Onset (- 2 - 2 . WERE AUTOPS: AMRIABLE PRA COMPLETION OF DEATH? 1 YES 2 [| FINDINGS OR TO OFF CAUSE |
| BY PHYSICIAN: MEDICAL C | 23. PART I. Enter the diseases, or complete the complete | DUE TO (CONTRIBUTE TO CAL HOSPITAL: 1 Zinpatient 2 D 28e. DATE OF III 28e. PLACE OF | Caused the dele on each line Off AS A CONSECT OFF AS A CONSECT OFF AS A CONSECT DEPTH AS A CONSECT OFF AS A | DUENCE OF DEAL TIME TO DO A 28b. TIME | In the ur S | nderlying NO only one) R: sing Nome 28c. INJU 1 y | g cause g Cause g UNC UNC S = Rei | ilven in i | Part I. 24a. | WAS AN A PERFORM YES 2 | atory arr | 24b | Approxinterva Onset (- 2 - 2 . WERE AUTOPS: AMRIABLE PRA COMPLETION OF DEATH? 1 YES 2 [| FINDINGS OR TO OFF CAUSE |
| BY PHYSICIAN: MEDICAL C | 23. PART I. Enter the diseases, or conshock, or heart feliure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Natural 5 Pending Investigation 3 Suicide 8 Could not be datermined | DUE TO (CONTRIBUTE TO CAL HOSPITAL: 1 Vingesters 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | caused the dele on each line on as a consecutive of the consecutive of | OUENCE OF DEAT PARTY. 1 | in the ur S | nderlying NO B: sing Nome 28c. INJI WO I Tory, office | Gause g Cause g Cul UNC UNC UNY AT RKY CES 2 | ERTAIN | Part I. 24a. B Other (Spe 28d. DESCRIBI | WAS AN A PERFORM YES 2 | JURY OCC | 24b. | Approxinterva Onset (- 2 - 2 . WERE AUTOPS: AMRIABLE PRA COMPLETION OF DEATH? 1 YES 2 [| FINDINGS OR TO OFF CAUSE |
| BY PHYSICIAN: MEDICAL C | 23. PART I. Enter the diseases, or complete the complete | DUE TO IT Caused the delete on each line ON AS A CONSECTOR ON AS A CONSECTOR DIP | DOMENCE OF DEAL TIME THE PROPERTY OF THE PROPERTY | in the ur S | 200 The moderlying NO R: sing Nome 28c. INJI Tory, office | g cause g Cuil UNC UNC UNC S G Rei | ilven in I | Part i. 24a. 1 | WAS AN A PERFORM YES 2 | JURY OCC | 24b. | Approxinterva Onset i WERE AUTOPS AMRILABLE PRI COMPLETION C OF DEATH? 1 YES 2 [| FINDINGS ON F CAUSE |
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| BY PHYSICIAN: MEDICAL C | 23. PART I. Enter the diseases, or complete the complete | DUE TO IT Caused the delete on each line ON AS A CONSECTOR ON AS A CONSECTOR DIP | DOMENCE OF DEAL TIME THE PROPERTY OF THE PROPERTY | in the ur S | 200 The moderlying NO R: sing Nome 28c. INJI Tory, office | g cause g Cuil UNC UNC UNC S G Rei | ERTAIN NO end due to bed at the to | Part i. 24a. B Other (Spe 28d. DESCRIB) 28f. LOCATION City or Record to the cause(e) time, date end g | WAS AN A PERFORM YES 2 VES | atory arr | 24b. 24b. curso or Rural F | Approxinterva Onset i WERE AUTOPS AMRILABLE PRI COMPLETION C OF DEATH? 1 YES 2 [| FINDINGS OR TO MY CAUSE |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BOHAN, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601 LAWRENCE O.
31. DATE FILED (Morith, Day, Year)
AUG - 3

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| CIA | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | 2 | MPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the | Ē | be filed within 72 hours after death with the State Dept. of Health and h | IMPORTANT: If Item 28 is marked, or item 23 shows any inj |

| | 1 - FOR STATE OF MARYLA | ND / DEPARTM | | | | AL HYGIEN | _ | | | | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------|--------------------------|-----------------------------|---------------------------------------------------------|-----------------|-------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DAT | E OF DEATN | | 3. TIME OF DEATH | | | |
| | SUSIE LEE | GERMAN | | | | 08 14 95 12:10 | | | | | |
| | | | UNDER I YEAR | IF UNDER 24 H | HRS. 7. DAT | E OF BIRTH | | BIRTNPLACE (State or Foreign Country) | | | |
| | 213-05-6243 1 M 2 M F 82 | YRS. | o. CITY, TOWN C | | | N. 22, | 1913 N | IARYLAND | | | |
| DIRECTOR | 98. FACILITY NAME (If not inelitation, give street end number) WILLIAM HILL HEALTH CARE RESIDENCE OF DECEDENT | | 9c. COUNTY OF DEATH TALBOT | | | | | | | | |
| REC | 10e. STATE 10b. COUNTY | 10c. CITY, T | OWN OR LOCAT | ION | | | | 10d. INSIDE CITY | | | |
| | MARYLAND TALBOT 100. STREET AND NUMBER | E | EASTON | ZIP CODE | | | 10. 0/7/25 | LIMITS? 1 X YES 2 NO N OF WHAT COUNTRY? | | | |
| FUNERAL | 501 DUTCHMAN'S LANE | | , | 216 | 501 | | US | | | | |
| S | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | | | | IN? (Specify Ye | o or No 14 | . RACE — American Indian, Black, White, stc. | | | |
| ВУ | 1 Never Merried 2 Merried FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, OIVE WAR OR DAT | | 1 Tyes, spe | cify Cuben, M 2 XNO S | lexicen, Puerti Specify: | Rican, etc.) | | Specific | | | |
| | | 16a. DECEDENT'S US | IAL COCURATION | | | | l | WHITE | | | |
| ETE | (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5 +) | (Give kind of work life. Do NOT use re | done during mos | st of working | 10 | 56. KIND OF BU | SINESS/INDUS | ТЯУ | | | |
| COMPLETED | 11 2 | TEACHER | 2 | | 1 | EDUCAT | TION | | | | |
| SO | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER | 'S NAME (First | , Middle, Maiden | Surname) | | | | |
| BE | JOHN SPRIGGS | | | AGN | IES M | ARSHAI | L | | | | |
| 70 | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILINO AD | | | | | | | | | |
| _ | HOWARD N. GERMAN, JR. | | BOX 8 | | EASTO | | | | | | |
| | | LISBURY | | | 1 | | | or Town, State | | | |
| | 4 Donation 6 Other (Specify) SALISBURY CREMATORY 8-14 SALISBURY, MD 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. | | | | | | | | | | |
| | JOHN R. MERLER | 1 . = . 0 | | | | | | | | | |
| | 23. PART I. Entar the diseases, or complications that caused | the deeth. Do not | enter the mod | de of dying. | Such as ca | udiac or read | ratory arrest | Approximate | | | |
| | anock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| | disease or condition resulting in death) | Corver | lot | 9 1 | mou | mon | - | 1 mill | | | |
| | OUE TO OR AS A | CONSEQUENCE OF): | | U | 700 | | | | | | |
| Z | Sequentially list conditions 5. | | | | | | | | | | |
| Ĕ | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 5 | CAUSE (Disease or Injury | | | | | | | | | | |
| CERTIFICATION | that Initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in deeth) LAST | | | | | | | | | | |
| CE | d | | | | | | | | | | |
| AL | PART II. Other algnificent conditions contributing to death but | not resulting in t | he underlying | ceuse give | n in Part I. | 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS | | | |
| 20 | generalized (Noterio | sam | | | | | D NO | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? | | | |
| WE | garhunon's Mision | È | | | | | 1 TES 2 NO | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | DEATH YES | □ NO □ | UNCER | TAIN 🔲 | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | B. PLACE OF DEATH (| Check only one) | | | | | | | | |
| YSI | 1 YES 2 NO 1 Inpetient 2 ER/Outpet | lent 3 DOA 4 | Noralng Nome | 5 🗆 Reside | ince 8 🗆 Oth | er (Specify) | | | | | |
| | 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | WOI | RK? | | SCRIBE HOW I | NJURY OCCUR | ED | | | |
| BY | 2 Accident Investigation 28e PLACE OF IN HIPPY | At home to see a see | | ES 2 NO | | 281. LOCATION (Street end Number or Rural Route Number, | | | | | |
| 8 | 4 Homicide 8 Could not be building, etc. (Specif) |) | r, lectory, office | | 281. EG | y or Town, State) | end Number or I | Rural Route Number, | | | |
| | 29e. CERTIFIER | | | | | | | | | | |
| COMPLETED | (Check only one) 1 CERTIFINO PHYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the basic of examination of the basic of | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CENTURIER | | Tiny opinion, or | | | e and piace, en | | | | | |
| BE | who sod h | | | 29c. LICENSE | NUMBER V | _ | 29d. DATE & | GNED (Mogeli, Day, Year) | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETES CAUSE OF DEAT | H (ITEM 27) (Type Prin | nf) | 100 | 2/17 | / | 0 | 111111 | | | |
| | William Hwood | E, | ASTO | N | MC | 1 | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. MEDISTRAR'S SIGNAT ALIC 16 1995 July Division | | | | | <u></u> | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

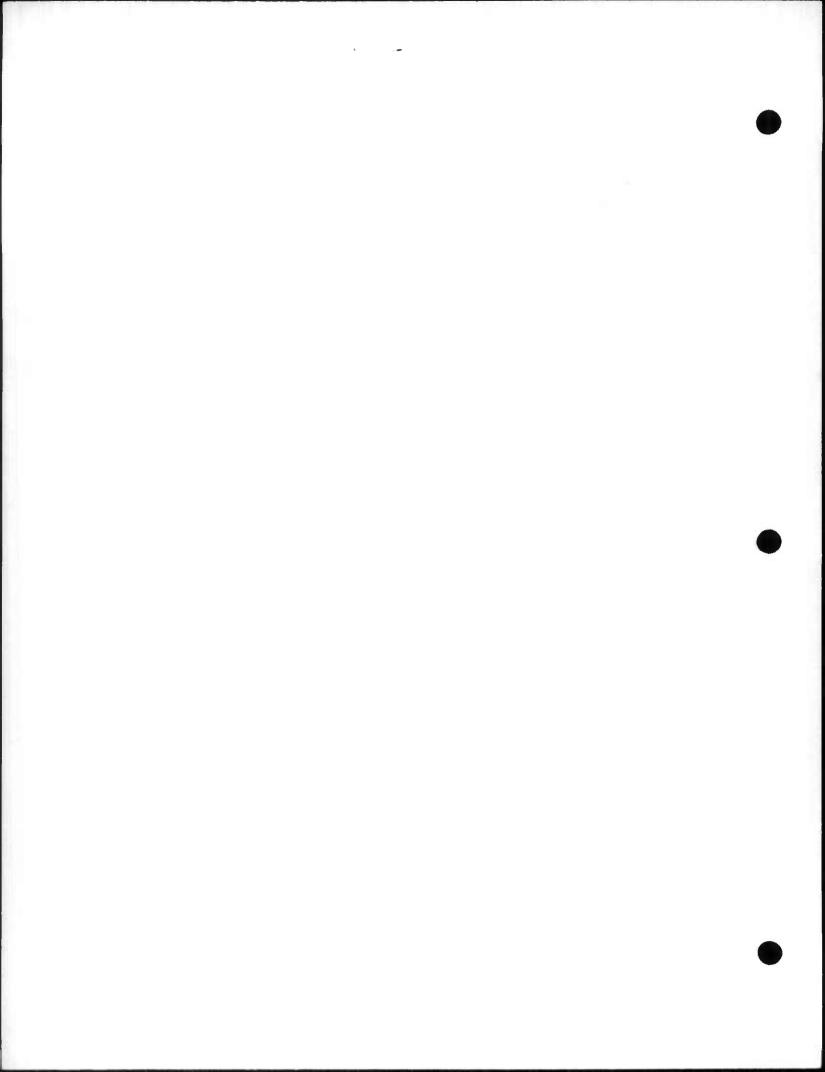
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1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

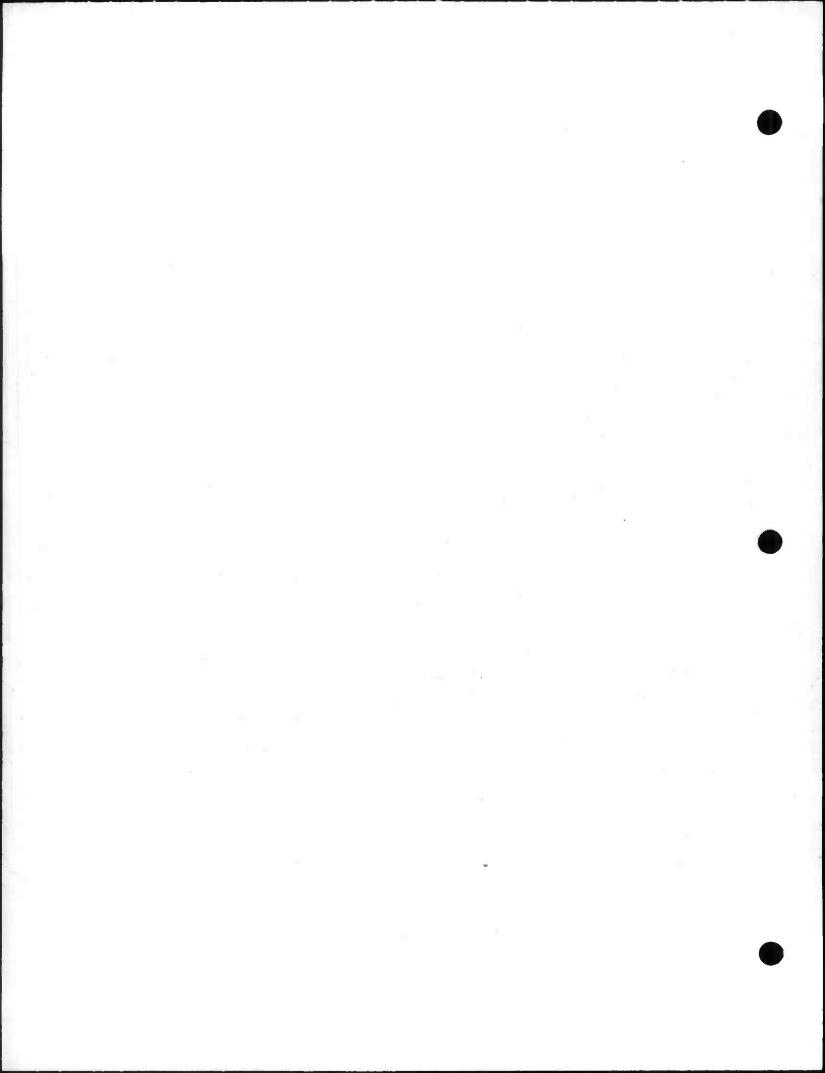
2. DATE OF DEATH DAY MONTH

| | TIEGIO TI UTI | | | 7611111 | CALL | . 01 | DEATI | | REG. NO. | | | | |
|---------------|-----------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------|-------------------------------|---------------|----------------------|-------------------------------------------------|------------------------------------------------------------------------------------|--------------------------|-----------------------|---------------------|-------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 1 | | | | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEAT | | | | | | |
| | Anna Frances | | Goldsmith | | | | 177 | | | | 995 | 9:55 P: M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | last birthday) | IF UNDER | 1 YEAR DAYS | IF UNDER 24 | | 7. DATE OF BIRTH | | 8. BIRTH Countr | IPLACE (State or Foreign | |
| | 210 21 0013 | 1 🗌 M 2 💢 F | 91 YRS. MONTHS BAYS HOURS MIN. Mar. 6 | | | | (Month, Day, Year) Mar. 6, | 1904 Maryland | | | | | |
| ~ | 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, | | R LOCATION | OF DEAT | ГН | 9c. COUR | 9c. COUNTY OF DEATH | | |
| 0 | Physicians Memorial Hospital | | | | | LaP. | lata | | | | Ch | arles | |
| EC | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | γ | | 10c, CIT | Y, TOWN O | R LOCAT | ION | | | | | 10d, INSIDE CITY | |
| DIRECTOR | Maryland Pri | Aqu | asco |) | 1520 | | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | | J - | 1 1 | | | ZIP CODE | | | 10a CITI | ZEN OF Y | VHAT COUNTRY? | |
| FUNERAL | 16300 St. Mar | v's Chu | rch Ro | ad | | 2.51 | 20608 | } | | | USA | WILL COUNTRY! | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN II S | PMED | 13. V | | | | ORIGIN? (Specify Yea | | | - American Indian, | |
| | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE W | YES 2 | NO | l H | yes, spe | cify Cuban, | Mexican, I | Puerto Rican, etc.) | | Black | c, White, atc. | |
| ВУ | 3 Widowed 4 Divorced | | | | 1 | _ 123 | 2. NO | орвону. | | 1 | Speci | White | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. C | DECEDENT'S | USUAL OC | CUPATIO | N et of working | | 16b, KIND OF BUS | INESS/IND | | | |
| 91 | Elementary/Secondary (0-12) | College (1-4 or 5 | .) | (Give kind of vite. Do NOT us | | | | | L _ | | | | |
| MP | 3 | | | entr | al S | Supp | oly W | lork | er Hosp | oita | 1 | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 711. | | (First, Middle, Maiden | , | | | |
| BE | William Franc | <u>is Bass</u> | | | | | | | Gertrude | | ~ | omery | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 1 | | | | | | ite Number, City or Town | | | | |
| | Helen Sponsle | r | | 1630 | 0 St | . 1 | Mary' | s C | h. Rd., | Aqui | asco | o, MD 2060 | |
| | 20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Rem | oval from State | 20b. PLACE | E AND DATE O | OF DISPOSI | TION /Na | me of | | DATE 20c. LOC | CATION - C | City or To | wn, State | |
| | 4 Donation 6 Characteristic | | Olic | lfiel | | | | | 8-30 Hi | ighe: | svi | lle, MD | |
| | 21. SIGNATURE OF CHERAL SERVICE LIGHNESS (1997) 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home | | | | | | | | | | | | |
| | Benjamin | Matthew | s M-00 | 658 | | | | | | » f | MD | 20604-015 | |
| | 23. PART I. Enter the diseases, or o | complications the | ceused the c | feath. Do n | ot enter t | the mod | de of dying | , auch a | na cardiac or reapir | atory arm | eat, | Approximata | |
| | shock, or heart failure. IMMEDIATE CAUSE (Final | List only one cau | se on sech lin | 10. | | | | | | | | Interval Between | |
| | disease or condition | | | | | | | | | | | | |
| | resulting in death) - s. Willer Colon (In as a consequence of): | | | | | | | | | | | | |
| z | | | | | | | | | | | | | |
| 은 | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | | | |
| E | that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| EH | resulting in death) LAST | d | | | | | | | | | | | |
| | PART II. Other aignificant condition | a contributing to | death but not | resulting i | n the und | terivina | cause give | en in Pa | rt I. 24s. WAS AN | Mattheev | 245 | WERE AUTOPSY FINDINGS | |
| EDICAL | Advance | - N. | • | | | | | | PERFORI | PERFORMED? AM | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | Hondaria | 9 19. | | | | | | | 1 TYES 2 | 1 YES 2 THO OF DEATH? | | | |
| Σ∥ | DID TOBACCO USE CONTI | DIDLITE TO CA | LICE OF DE | ATLL VE | c \square N | | LINICEE | DTAINI | _ | | | 1 TES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | NIBUTE TO CA | | CE OF DEAT | | | UNCER | KIAIN | | | | | |
| 잃 | EXAMINER? | HOSPITAL: | | T | OTHER: | : | 5 - IV | | - W W. | | | | |
| ¥∥ | 27. MANNER OF DEATH | 28e. DATE OF | | 20b. TIMI | | ng Home 28c. INJL | ome 6 Residence 6 Other (Specify) | | | | | | |
| | 1 Natural 5 Pending | (Month, Di | ly, Year) | INJ | | WOR | | - 1 | ou. DESCRIBE NOW IN | INJURY OCCURED | | | |
| à | 2 Accident Investigation 3 Suicide | 28s. PLACE OF | FINJURY — At h | ome, term e | treat factor | | 20 2 0 1 | | M LOCATION (Street or | od Abronhau | on Durast D | | |
| | 4 Homicide 6 Could not be determined | building, | etc. (Specify) | | | ry, omca | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | oute Number, | |
| <u> </u> | 29a. CERTIFIER | | | | | | | | | | _ | | |
| COMPLETED | | | | | | | | | the cause(s) and mane | | | | |
| 8 | | | amination and/or | Investigation | n, in my op | Inlon, de | ath occured | coursed at the time, date and place, and due to the cause(s) and manner as stated. | | | | and manner as stated. | |
| W | 296. SIGNATURE AND TITLE OF CERTIFIEF | | | | | | 29c. LICENS | | in . | 29d. DATE | SIGNED | (Month, Day, Year) | |
| 2 | 20 MANE AND ADDRESS OF THE | | | | | | <i>IJ</i> −2 | 5992 | | 18 | 121 | 7/9/ | |
| - | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | | | |
| | Khadar Baig MD 6620 (| rain Highw | av Suite | 102 La | Plata | . Mc | 20646 | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | | Akualan- | 0 | | | | | | | | | |
| | AUG 2 9 1995 | Jack o | U KUGULAK I | rardally | | | | | | | | | |
| | | | | | | | | | | | | | |



| BALLIMORE, MARYLAND | ours after death. Page 6 may be retained by the hosp | in by the funeral director, page 5 should be detacher removal. | nedical examiner must be notified at once. | |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, F.O. BOX 68/60 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | 0 | | | 2. DATE OF DEATN | | 3. TIME OF DEATH |
| | Leonard | NMN Gilbert | | | | AUGUST 32, 1995 7: | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8.1 | BIRTHPLACE (State or Foreign |
| | 072-14-6284 BB. FACILITY NAME (If not institution, give | | 73 YRS. | MONTHS DAYS | | June 30, | 1922 N | ew York |
| S S | | | | Gaithers | R LOCATION OF DEA | ATH | Montgo | |
| ٦ | Shady Grove Adven RESIDENCE OF DECEDENT 100. STATE 100. COUNT | | | | | | IMontge | |
| DIRECTOR | | | | TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Mont | gomery | Ga1 | thersbu | ZIP CODE | | 1 YES 2 NO OF WHAT COUNTRY? | |
| FUNERAL | 792 Quince Orcha | rd Blvd T-1 | | 1 | 20878 | | | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | N U.S. ARMED | 13. WAS DEC | ENDENT OF HISPANI | C ORIGIN? (Specify Ye | | States RACE — American Indian, Black, White, etc. |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 X YES | | If yes, spe | city Cuban, Mexican 2 X NO Specify: | , Puerto Rican, etc.) | | Canalia |
| | 15. DECEDENT'S ED | WWII | 40 - 0000000000000000000000000000000000 | | | | | White |
| COMPLETED | (Specify only highest grad | le completed) | (Give kind of we life. Do NOT use | ork done during mo- | N st of working | 16b. KIND OF BU | SINESS/INOUST | RY |
| P | Elementary/Secondary (0-12) | College (1-4 or 5 +) | SalesMan | | | Colos | Dorran T | donad bundan |
| OM | 17. FATNER'S NAME (First, Middle, Last) | | Dalesman | | 18. MOTHER'S NAM | E (First, Middle, Maiden | | Distribution |
| ш | Jacob NMN Gilber | t | | | Ann Ha | rris | , | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | AOORESS (Street as | | oute Number, City or Tow | m, State, Zip Coo | (e) |
| - | Betty Craighead | | 792 Qu | ince Ord | hard Blv | d.Gaither | sburg, | MD 20878 |
| | 20a. METNOD OF DISPOSITION 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren | | PLACE AND DATE OF | F DISPOSITION (Namer place) | me of | DATE 20c. LO | CATION City | or Town, State |
| | 4 Dopation & Other (Specify) 21. SIGNATURE OF HUNERAL SERVICE LI | Ha | gerstown | Cremato | | 8/23 Hag | erstown | , Maryland |
| | d de la constante de la consta | CENSEE | | Stauff | er Funer | al Homes, | P.A. | |
| | KUUW /U | . Ollicer | | 1621 0 | possumto | wn Pike, | Frederi | .ck, MD 21702 |
| | 23. PART I. Enfor the diseases, or shock, or heart feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. Puller | CONSEQUENCE OF | | | | ratory arreat, | Approximata Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| AL O | PART II. Other significent condition | ns contributing to deeth b | ut not resulting in | the underlying | cause given in P | | | 24b. WERE AUTOPSY FINDINGS |
| | Suplanie H | with Dix | de | Syca | anore | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDIC | Call Cane | y, Ronal | Freder | e, Du | guson | 0>- | | 1 YES 2 NO |
| z l | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | F DEATH YES | □ NO □ | UNCERTAIN | | | |
| ᅙ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 28. PLACE OF DEATH | (Check only one) OTHER: | | | | |
| PHYSICIAN: | 1 XES 2 NO 27. MANNER OF DEATH | 1 Inpatiant 2 ER/Outp | effent 3 DOA | 4 - Nursing Name | 5 Residence 6 | | | |
| BY PI | 1 Natural 5 Pending Investigation | (Month, Day, Year) | 28b. TIME INJU | RY WOI | JRY AT RK? ES 2 NO | 28d. OEŞCRIBE HOW I | NJURY OCCURE | D |
| | 3 Suicide 6 Could not be 4 Nomicide determined | 28s. PLACE OF INJURY building, etc. (Spec | — At home, ferm, str | reet, factory, office | | 26f. LOCATION (Street of City or Town, State) | and Number or R | ural Route Number, |
| COMPLETED | | SICIAN: To the best of my knowl | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | Tando Investigation | , in my opinion, or | | | | |
| TO BE | Drugero | 3. The | rmak | 9 100 | DZ73 | 9 (| 29d. DATE SIG | INED (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WE DOUBLAS R. | SHUMALER | ATH (ITEM 27) (Type, F | Rock | VILLE | MA | RY AT | 50 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRANIS SIGNA | ATURE RONALLE | | , | | | |
| | AUG 2 5 199 | 3 Juna aluda | STANDAR WAS | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ted, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exec | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to bu | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumati | |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | ENT OF H | EALTH AND I | MENTAL HYGIENE REG. NO. | | | | |
|---------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------|----------------------------------------------------|-------------------------------|----------------------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | MADIODIE | | NKIEWIC | | 2. DATE OF DEATH MONTH DAY | 1995 | 3. TIME OF DEATH 9:50 P M | | |
| | 4. SOCIAL SECURITY NUMBER 226-50-7873 | 1 - M 2 F F | 7 YRS. MO | UNDER 1 YEAR ITHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 6/19/19 | 8. BIRT | THPLACE (State or Foreign | | |
| TOR | 90. FACILITY NAME (If not institution, given GREATER BALTIMO | PRE MEDICAL CF | ENTER | | R LOCATION OF DE | АТН | 9c. COUNTY OF | IMORE | | |
| DIRECTOR | 10a. STATE 10b. COUN | Harford | 10c. CITY, TO | Jarr | ettsvi | lle | | 10d. INSIDE CITY LIMITS? t YES 2 NO | | |
| FUNERAL | | imm Road | | 101. | ZIP CODE 2108 | 4 | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 8 | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 NO | | city Cuban, Maxica | IIC ORIGIN? (Specify Yes n, Puarlo Rican, etc.) | or No — 14. RAG Ble Spe | CE — American Indian, ck, White, atc. scily: aucasian | | |
| COMPLETED | 15. DECEDENT'S EE (Specify only highest gra | DUCATION ide completed) College (1-4 or 5+) | 16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret | done during mos ired.) | N t of working | 16b. KIND OF BUSI | NESS/INDUSTRY | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | Homems Bradley | ker | 16. MOTHER'S NAI | ME (First, Middle, Melden S UNKNOV | | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Eugene J. Gr | ynkiewicz | | | d Number or Rural F | noute Number, City or Town, | | | | |
| | 20 METHOD OF DISPOSITION 1 Burlel 2 Crematton 3 Re 4 Donation 6 Other (Specify) | emoval from State | PLACE AND DATE OF DE netery, crematory or other p | lem. G | ardens | 8/24 Fal | ATION - City or T | Town, State Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE I | Iden Turk | 1/11 | Ku | rretts | neral Hon | nelva | A | | |
| | 23. PART I. Enter the diseases, or ahock, or heert fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | r complications that caused. List only one ceuse on e | of the death. Do not a sech line. | nter the mod | tic C | as cardiac or reapin | story arrest, | Approximata Interval Between Onset and Death | | |
| TION | Sequentially list conditions, if any, leading to immediate | · metas | CONSEQUENCE OF): | 8410 | ulcel | le lung | 00 | LONW | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | c. DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| AL | PART II. Other algnificent condition | one contributing to deeth b | ut not resulting in th | e underlying | cause given in i | PERFORM | ED? | b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE | | |
| N: MEDIC | DID TOBACCO USE CON | TRIBUTE TO CAUSE O | F DEATH YES | NO 🗆 | UNCERTAIN | 1 | INO | OF DEATH? | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 26. PLACE OF DEATH (Continued of the state o | HER: | 5 - Residence | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | | 28b. TIME OF INJURY | | | 28d. DESCRIBE HOW IN. | | | | |
| LEIED | 3 Suicide 8 Could not be determined | building, etc. (Spec | | | | 28f. LOCATION (Street an City or Town, State) | | Route Number, | | |
| COMPLE | | SICIAN: To the best of my knowl | | my opinion, der | ith occured at the t | ime, date and place, and | due to the cause(| | | |
| 20 00 | 30. NAME AND ADDRESS OF PERSON W | COMPLETED CAUSE OF DE | ITH (Type, Print) | | 29c. LICENSE NUM | 8594 | DATE SIGNED | 0 (Month, day, Year) 20 95 | | |
| | Auth Kanton MI 31. DATE FILED (MONTH), DOY, YOUNG | D GSGAN, OV | wheests | inte d | 210 Bal | to, MD | 2120 | 4 | | |
| | HUU2 8 1995 | Java a nouses | - or Adval | | | | | 11 - 4 3 18 3 | | |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 5 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be filed writin it, hours after obain with the State Dept. or health and wenter hygene prior to burial, chemidian, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once. |
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| TO THE HOSPITAL | TO THE FUNERAL | De med within /2 |

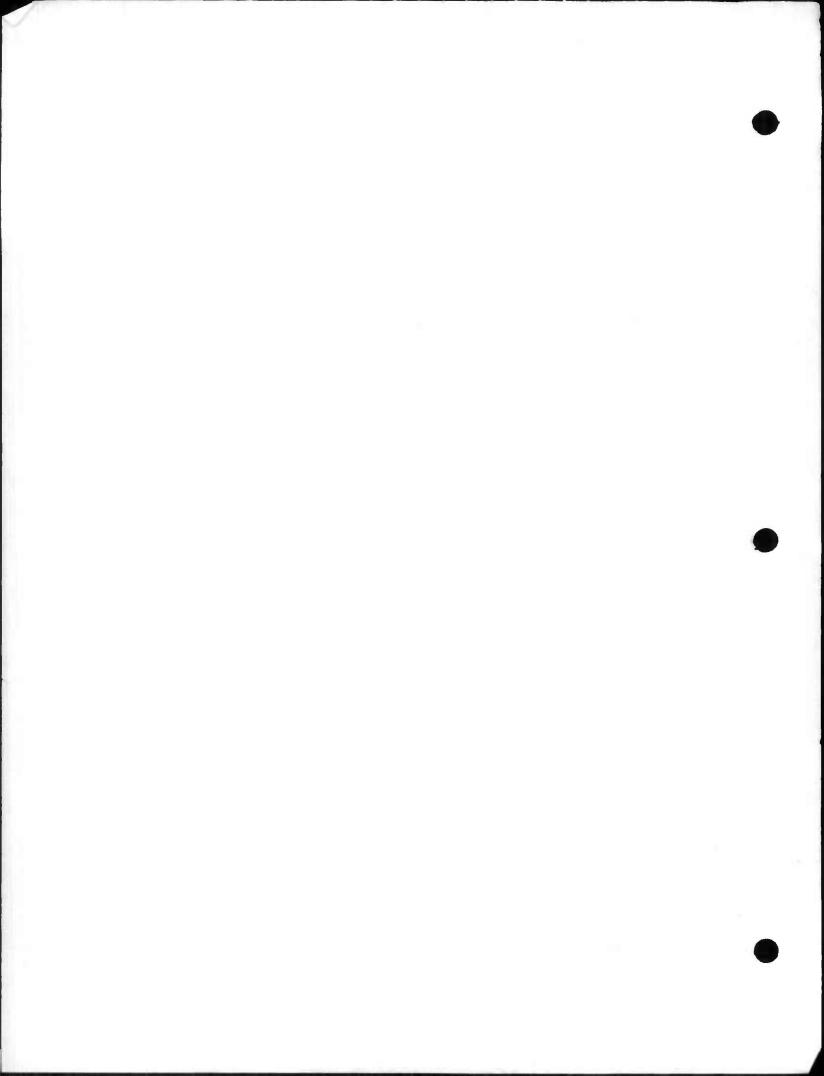
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM CERTIFICA | | | MENTAL HYGIEN | E | | | |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------|----------------------|-----------------------|------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| - 3 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | ATH 3. TIME OF DEATH | | | | |
| | CATHERINE | ELIZABETH GRIN | | | | AUGUST 20 | 4 4 4 | 1:55AH | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | | RS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign | | | | |
| 1000 | 214-48-1916 1 M 2X F 73 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) June 16, 1922 9e. FACILITY NAME (If not inetitution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNT | | | | | | | aryland | | |
| DIRECTOR | Lorien Nursing & | Lorien Nursing & Rehabilitation Ctr. BELCAMP, MARYLAND Harfo | | | | | | | | |
| REC | 10e. STATE 10b. COUNTY | 1 | 10c. CITY, TO | WN OR LOCAT | ON | | 100 | 10d. INSIDE CITY LIMITS? | | |
| | Maryland Har | ford | Abi | ngdon | | | | 1 TYES 2 NO | | |
| FUNERAL | 3701 Deer Chase C | ~ | | | ZIP CODE 21009 | | USA | WNAT COUNTRY? | | |
| NE. | 11, MARITAL STATUS | 12. WAS DECEDENT EVER IN | II C ADMED | | | C ORIGIN? (Specify Yes | | | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes, spe | cify Cuban, Mexican | , Puerto Rican, etc.) | Ble | CE American Indian, ck, White, atc. | | |
| BY | 3 🔀 Widowed 4 🗌 Divorced | IF YES, GIVE WAR ON DAI | ies | 1 L YES | 2 X NO Specify: | | Spe | White | | |
| | 15. DECEDENT'S EDUI (Specify only highest grade | | 16a. DECEDENT'S USU | | | 16b, KIND OF BUS | INESS/INDUSTRY | | | |
| Ē | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use ret | red.) | t of working | | | 77 | | |
| P. | 8 | | Homemak | er | | Home | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAM | ME (First, Middle, Maiden | Sumame) | | | |
| BE (| Clarence Earl Smi | th | _ | | Laura Ma | arie Niser | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | - | 19b. MAILING ADD | RESS (Street ar | nd Number or Rural Re | oute Number, City or Town | , State, Zip Code) | | | |
| F | Darlyn C. Goles | | 3701 De | er Cha | se Ct., 1 | Abingdon, | Maryland | 21009 | | |
| | 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rem | oval from State came | PLACE AND DATE OF DI | Jacol | | | CATION — City or 1 | | | |
| | 4 Donation 5 Other (Specify) | Ba | ker's Cem | etery | | 29-95 Aber | deen, Ma | aryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LA | 11/19/ | 1. | | D AODRESS OF FAC | Comas III | Funeral | I-one | | |
| | 1 / Duras K | MA | - Elb | | | ry Rd., Ab | | The state of the s | | |
| | 23. PART I. Enter the diseases, or o | complications that caused | the death. Do not e | nier the mod | le of dying, such | as cardiac or respi | retory arrest, | Approximate | | |
| | immediate cause (Final | List only one cause on ea | ch line. | | / - | | | Interval Between Onset and Death | | |
| - 4 | disease or condition resulting in death) | | | | | | | | | |
| | reaulting in death) | DUE TO (OR AS A | CONSEQUENCE OF): | w par | | | / | autenan | | |
| z | Sequentially list conditions, Due to (or As A consequence of): Due to (or As A consequence of): Due to (or As A consequence of): | | | | | | | | | |
| 5 | ii airy, leading to miniadiate | | | | | | | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | |
| # | that inflated events resulting in death) LAST | | | | | | | | | |
| CERTIFICATION | resulting in death) Exist | d | | | | | | | | |
| AL C | PART II. Other aignificant condition | s contributing to death bu | t not/resulting in th | e underlying | ceuse given in F | Part I. 24s. WAS AN | AUTOPSY 24 | b. WERE AUTOPSY FINDINGS | | |
| S | Lancerie N | estructing | 1/4/cru | de | eure | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| 8 | 6.00 | | | 7 | | 1 YES 2 | XNO | OF DEATH? | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF E | EATH Y | ES X NO | | | 1 YES 2 NO | | |
| IAI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 28. PL | ACE OF DEATH (Che | ck only one) | | | | |
| Sic | 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outpe | tlent 3 DOA X | HER: Nursing Home | 5 Residence | B Other (Specify) | | | | |
| Ž | 27. MANNER OF DEATH | 26a. DATE OF INJURY | 28b. TIME OF | 28c. INJU | | 28d. DESCRIBE HOW II | NJURY OCCURED | | | |
| BY | 1 Natural 5 Pending Investigation | (Month, Day, Year) | INJURY | M 1 Y | ES 2 NO | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY - building, etc. (Specifi | At home, ferm, street | , fectory, office | | 281. LOCATION (Street a | and Number or Rural | Route Number, | | |
| | 4 Homicide determined | bulleting, etc. (opecin | , | | | City or Town, State) | | | | |
| 1 6 | 290. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my knowle | dge, death occurred at | the time, data | end place, end due t | to the cause(s) and men | ner se stated | | | |
| COMPLETED | | R: On the besis of examination | | | | | | (e) end menner es stated. | | |
| | 296, SIGNATURE AND TOTAL OF CENTIFIES | | | | 29c. LICENSE NUM | | | D (Month, Day, Year) | | |
| B | 7/1/2 | Total San | | | 4501 | ファラ | M. J | 1 1/ 1001 | | |
| 임 | O NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, Prin | 1) | 11570 | CC | HUGH | 157 26/175 | | |
| - 1 | BETER I die | 54' 75 | | | 185 Cy | 6 1.C. 0 | Edgen | melal | | |
| | 31 DATE EN ED (Month Day Mar) | 32. HEGISTRAR'S SIGNA | TUBE | 76670 | 250 | n voy k | - eg ccc | CVC | | |
| | AUG 2" 9" 1995 | 32 REGISTRAR'S SIGNA | Mardall | | | | | | | |

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| BALTIMORE, MARYLAND 21215-0020 | E | p R | |
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| 9 | 8 | an | 0 b |
| BOX 68760, | cate be executed within yours after death. Page 6 may be retained by the hospital or attending physician. | physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | e prior to burial, cremation, or removal. |
| B | cate | mysi | nd e |
| | | | |

1 -

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | | GIENE 3. NO. |
|-------------------------------------|-------------------------------------------------------------------|---------------|-----------------|
| CEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DE | ATH |

| | | ij | 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
|------------------|-------------------------------------------------------|------------|------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------|-----------------|-------------------------|-----------------|-------------|----------|-------------------|----------|----------------------------------------|-------------|------------|--------------------------------------------------------|
| | | | Neva M. Gr | ant | | | | | | | | | MONTH August 2 | 2 19 | 95 | 8:55 P M |
| | | | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 6. AGE (In | yrs. lest b | oirthday) | IF UNDER | | IF UNDER | | 7. DATE OF BIRTH (Month, Day, Year) | | | PLACE (State or Foreign |
| | 9 | | 579-66-254 | | 1 □ M 2 🏋 F | | 95 | YRS. | MONTHS | DAYS | HOURS | MIN. | October 2 | | | ginia |
| | 3 should | | 9a. FACILITY NAME (If not is | | | | | | | | OR LOCATI | | ATH | 9c. COU | NTY OF D | |
| | 2, 3 | DIRECTOR | Wilson Hea | | re Cente | r | | | G | ait | hersb | urg | | M | ontg | omery |
| | 1, | EC | 10e. STATE | 10b. COUNT | Υ | | | 10c. CIT | Y, TOWN C | R LOC | ATION | | | | | 10d. INSIDE CITY |
| | P | 듬 | Maryland | Mont | gomery | | | Ga | ithe | rsb | urg | | | | - 1 | LIMITS? |
| | permit. Pages 1, 2, | ¥ | 10e. STREET AND NUMBER | | | | | | | 11 | of. ZIP COD | E | | 10g. CIT | IZEN OF W | WHAT COUNTRY? |
| | Sit | FUNERAL | 201 Russel | 1 Aven | ue | | | | | | 2087 | 7 | | U. | S.A. | |
| 0 | burial-transit | 5 | 11. MARITAL STATUS 1 Never Merried 2 | 145.00 | 12. WAS DECEDER | NT EVER IN U | U.S. ARMI | ED | | | | | HC ORIGIN? (Specify Y | ee or No- | 14. RACE | — American Indien, |
| 00 | a pd | ВУ | 3 X Widowed 4 Div | | IF YES, GIVE Y | WAR OR DAT | ESA | | | | S 2 NO | | | | Speci | ty: |
| 215-0020 | as t | 8 | 15. DEC | CEDENT'S EDU | CATION | | 16a. DECE | DENT'S | USUAL O | CCUPAT | ION | | 16b. KIND OF B | ISINESS/INC | | ite |
| 212 | for use | — I | (Specify on Elementary/Secondary (| ly highest grade 0-12) | College (1-4 or 5 | _ | (Give | kind of v | vork done (| during m | nost of worki | ng | | | | |
| Q | hed f | P. | 12 | , | | | Но | mem | aker | | | | Own | Home | | |
| LAND | detached for use as the bunal-tran. | COMPLE | 17. FATHER'S NAME (First, A | | | | | | | | | | ME (First, Middle, Meide | | | |
| | 8 G | BE (| Hubert Bea | | | | | _ | | | | illi | am Mae Gl | adden | | |
| MARY | 5 should notified | 2 | 19e. INFORMANT'S NAME (| | | | | | | | | | Route Number, City or To | | Code) | |
| E, F | page 5 | | Marian G. | | | | | | | | | IC HI | .11, VA 22 | | | |
| ALTIMORE, | ector, p | | 20a. METNOD OF DISPOSIT | n 3 🗆 Rem | oval from State | | PLACE AN tery, creme | | | | Name of al Par | 1 | | OCATION - | | |
| IM | direc | | 4 Donation 5 Other 21. SIGNATURE OF TUNERA | | CENSEE | / Na | at10 | nal | | | | | 8/26 Fa | | | Sons, Inc. |
| ALTIMOR | tuneral director, L examiner must | 1 | 1 / | J | 1 1 | | | | 51 | 30 | Wisco | nsin | Avenue, | N.W. | 1 5 | bolls, Inc. |
| BA | 9 70 - | _ | Le | ner | U Y | w | u | س | Wa | shi | ngton | ı, D. | C. 20016 | | | |
| 8 | E - 9 | | 23. PART I. Enter the d ahock, or h | leart feilure. | List only one car | use on eac | the deet ch iine. | th. Do n | ot enter | the m | ode of dy | Ing, auc | h aa cardlac or rea | piratory an | reat, | Approximata Interval Between |
| | ion, and | ł | IMMEDIATE CAUSE (Find disease or condition | | 0 | , , | | 1 | | _ | 1. | | | | | Onset and Death |
| 0, | completely fille ial, cremation, event, the | - 1 | disease or condition resulting in death) a. Cerebral Orteriosclerosis Due to (or as a consequence of): 3 year | | | | | | | | | | | 3years | | |
| 68760 | 5 - 5 | - | | | nathere. | (011 110 11 0 | 00110200 | ENOL O | ,. | | | | | | | |
| | OF | CATION | Sequentially list condit If any, leeding to imme | | DUE TO | OR AS A C | CONSEQU | ENCE OF | F): | | | | | | | |
| ВОХ | 5 0 | 8 | CAUSE (Disease or injury | | | | | | | | | | | | | |
| .O. B | | E | that initieted events resulting in death) LAS | | OUE TO | OR AS A C | CONSEOU | ENCE OF | F): | | | | | | | |
| 0 | 5 0 | CERTIFI | readiting in death) LAS | " | d | | | | | | | | | | | |
| DS, P | E Me | - 11 | PART ii. Other algolfice | | | deeth but | t not res | suiting I | In the un | deriyi | ng cause | given in | Part I. 24s. WAS A | N AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| ECORD | signed by t Health and ws any in | MEDICAL | ESORN | raea | | | 2 | 1 | aci | oh | aral | | t ¬ YES | 2 WHO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| RECOR | n signed r Health | MEC | vascul | ar | disea: | se | , | | |) | | | | | | 1 VES 2 NO |
| _ i | ا سے تے ہے | | DID TOBACC | O USE | CONTRIBUT | E TO | CAUS | E OF | DEA | TH | YES [|] NO | | | | X |
| | ficate has State Dep Item 23 | PHYSICIAN: | 25. WAS CASE REFERRED 1 EXAMINER? | O MEDICAL | HOSPITAL: | | | | OTHER | | PLACE OF D | EATH (Ch | eck only one) | | | |
| Z | certificate the State | YSI | 1 TYES 2 NO | | 1 Inpatient 2 | | | | Nun | lng Ho | | esidence | 6 Other (Specify) | | | |
| OF | fler this c eath with marked, | | 27. MANNER OF DEATH 1 Natural 6 | Pending | 26e. DATE OF (Month, I | Pay, Year) | | 28b. TIM INJ | URY M | W | JURY AT | | 28d. DESCRIBE NOW | INJURY OC | CUREO | |
| NO | After death s mar | ВУ | 2 Accident | Investigation | 28e. PLACE (| OF INJURY - | – At home | e ferm | | | YES 2 | NO | 28f. LOCATION (Stree | t and Mumbu | or Promi 6 | Procto Morenbar |
| SI | after 28 Is | 8 | 3 Suicide 6 4 Homicide | Could not be determined | building | , atc. (Specify | (y) | , ,,,,,,, | | o. y, o | | | City or Town, Stat | e) | OF PUREL | louie Namber, |
| DIVISION OF VITA | DIRECTOR: hours after item 28 i | Ē | 29e. CERTIFIER | TIEVING BUVE | ICIAN: To the heat o | d min benedict | 4 | | | | | | | | | |
| | 1 2 5 | COMPL | | | | | | | | | | | to the cause(a) and m | | | and menner es stated. |
| - INCORPORA | TO THE FUNERAL be filed within 72 IMPORTANT: If | | 29b. SIGNATURE AND TITLE | | | | | | | , | _ | | | - | | |
| Ę | Po F | H, | | | 10 | h. | 7 | | m | 2 | 296. LIC | ENSE NUI | O / | ≥ A | E SIGNED | (Month, Day, Year) |
| £ | 288 | 5/ | 30. NAME AND ADDRESS D | F FERSON WE | D.COMPLETED CAU | JSE OF DEAT | TN (ITEM | 27) (Type, | Print) | | | 13 | 31 | 1 17 | ugu: | 17 23,1995 |
| 15 | | | James 6 | R. m | 100 cac | 1 | 207 | F | 3 | 20 | A | UC | Gaither | Shu | n. | A 20 877 |
| | | | AUG 25 19 | Year) | 32. REGISTA | | | | | 70 | 7 17 | 7 | 11176 | JUNC | | 20071 |
| | | | HUG 45 19 | 395 | THE WINDS | WALC | -dead | | | | | | | | | |
| | | | ^ | | | | | | | | | | | | | DHMH. 1/8 Ray 1/89 |

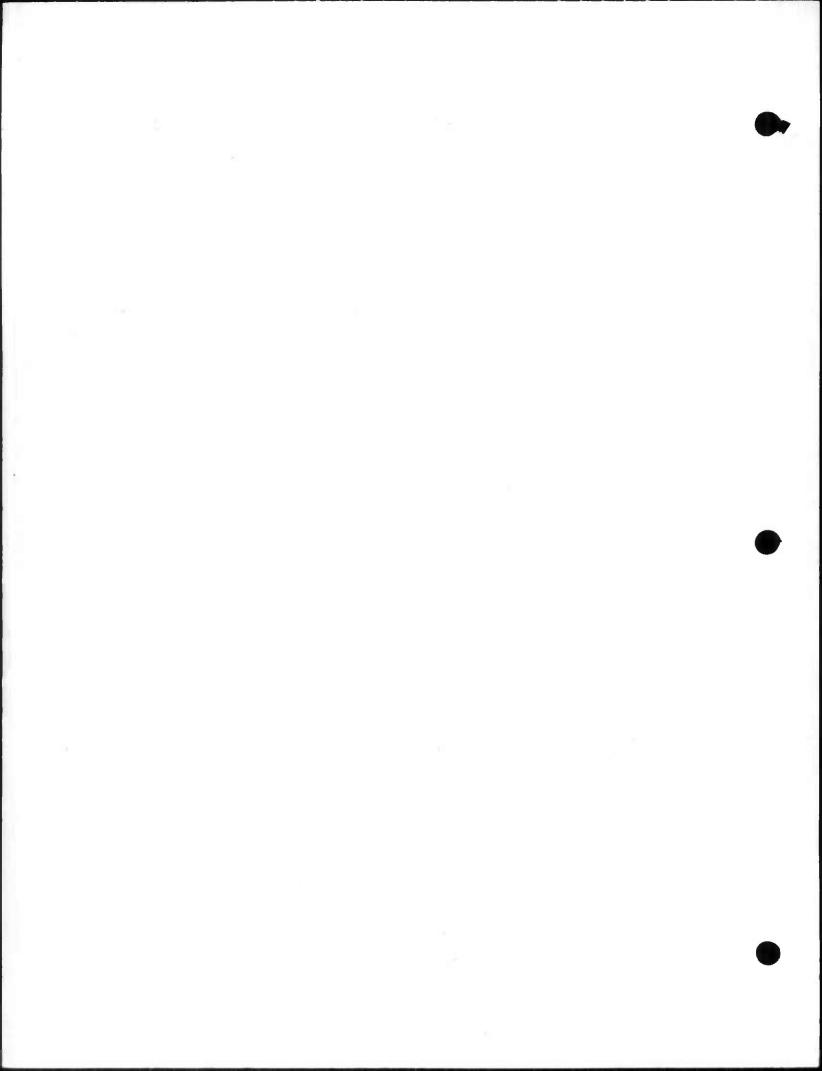


DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR | |
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| 1 | STATE | |
| | REGISTRAR | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFI | CATE O | F DEATH | F | REG. NO. | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------|--------------------|-------------------------------------|-------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH AND YEAR 3. TIME OF DE | | | | 3. TIME OF DEAT | Н |
| | Carlos Manuel Bue | | Lez | | | | August 18, 1995 | | | Рм |
| | 4. SOCIAL SECURITY NUMBER 212-25-2570 | 5. SEX 6. AGI | E (In yrs. last birthday) 6 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF I | BIETH | 8. BIRTI | NPLACE (State or Fo | reign |
| _ | Sa. FACILITY NAME (If not institution, give stre | | | | OR LOCATION OF D | | | UNTY OF E | | |
| DIRECTOR | Holy Cross Hospit | al | | Silve | r Spring | | Mo | ontgo | mery | |
| RE | 10s. STATE 10b. COUNTY | | | TOWN OR LOC | | | | | 10d. INSIDE CITY | |
| | Maryland Monto | jomery | Ro | ckvill | | | | | 1 YES 2XX | NO |
| FUNERAL | 12516 Veirs Mill F | | | | 20853 | | | | States | |
| 5 | 11. MARITAL STATUS XX Never Married 2 Merried | 12. WAS OECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS D | ECENOENT OF HISPAI | NIC ORIGIN? (S | pecify Yes or No- | 14. RACI | E — American India | ın, |
| BY | 3 Widowed 4 Divorced | IF YES, OIVE WAR OR | | 1 (X Y | s 2 🗆 NO Specification No. 1 | v: | 1, 4000 | Spec | | |
| | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION completed) | 16s. DECEDENT'S I | | TION | | D OF BUSINESS/II | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | itte. Do NOT use | retired.) | Total of Worlding | | educatio | nn. | | |
| O | 17. FATHER'S NAME (First, Middle, Last) | | 30000 | 7110 | 18. MOTNER'S NA | | e, Maiden Sumame | | | - |
| BE C | Carlos Manuel Buer | rgos | | | The state of the s | Gonzal | | | | - 1 |
| 0 | 19e, INFORMANT'S NAME (Type/Print) | | 19b. MAJLINO | ADDRESS (Street | t and Number or Rural | Route Number, C | City or Town, State, 2 | Zip Code) | | |
| ۴ | Clara Buergos (Mot | her) | same | as #10 | | | | | | |
| | 20e. METHOD OF DISPOSITION X XBurlei 2 Cremetion 3 Remove | val trom State Co | b. PLACE AND DATE O | FDISPOSITION (| Name of | DATE | 20c. LOCATION - | | | |
| | 4 Donation 6 Other (Specify) Gate of Heaven Cemetery 8-22 Silver Spring, Maryland | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Av. Silver Spring. MD 20910 | | | | | | | | | |
| CERTIFICATION | 21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the complete of the cause on each line. Approximate interval Between Onset and Death | | | | | | | | | |
| ERTIFI | CAUSE (Disease or Injury that Initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | |
| | | | | | | | | . WERE AUTOPSY FIR | IDINGS | |
| MEDICAL | | | | | | | PERFORMED? | | AMILABLE PRIOR 1 COMPLETION OF C | |
| N. | | | | | | _ ^ | X .20 2 10 | | OF DEATH? | |
| ž | DID TOBACCO USE CONTRI | BUTE TO CAUSE | OF DEATH YES | □ NO I | UNCERTAI | NO | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH | (Check only on | 9) | | | | | |
| YSI | 1 X YES 2 NO | 1 Inpatient 2XXER/Ou | tpatient 3 DOA | 4 - Nursing No | me 5 Residence | 6 Other (Sp. | ecify) | | | |
| ВУ РН | 27. MANNER OF DEATN 1)(2) Natural 5 Pending 2 Accident Investigation | 26s. DATE OF INJURY (Month, Day, Year) | | RY V | IJURY AT PORK? YES 2 NO | 28d. DESCRIE | BE NOW INJURY O | CCURED | | |
| G | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, etc. (Sp | IY — At home, term, at ecify) | reet, factory, of | Ice | 281. LOCATIO City or To | N (Street and Numb wn, State) | er or Rural F | Route Number, | |
| COMPLET | | AN: To the best of my kno | | | | | | | i) and manner sa at | ited. |
| | 296. SIGHATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUM | MBER | 29d. DA | TE SIGNED | (Month, Day, Year) | |
| TO BE | | | | | O.C.M.E | | | | t 21, 19 | 95 |
| | 30. NAME AND ADDRESS OF PERSON WHO | | | | Baltimor | e, Mar | vland 2 | 21201 | | |
| | 31. DATE FILED (Month Day, Year) AUG 25 1995 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | | | | | | | | | | - 1 |



3. TIME OF DEATN

10d. INSIDE CITY

1 YES 2 X NO

a. BIRTHPLACE (State or Foreig

NEW YORK

9c. COUNTY OF CEATN

MONTGOMERY

10g. CITIZEN OF WHAT COUNTRY?

UNITED STATES

Specify:

t4. RACE — American Indian, Black, White, etc.

WHITE

Approximate

Interval Batwe

Onset and Death

15 MON

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

294. DATE SIGNED (Movilly, Day)

02:30A

REG. NO

22

2. DATE OF DEATN

August

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FOR STATE

REGISTRAR

osep

t. DECEDENT'S NAME (First, Middle, Last)

ichard

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4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Ybar) HOURS 072-42-3878 DAYS 1 X M 2 | | 46 YRS JULY 28,1949 Pages 1, 2, 3 should Se. FACILITY NAME (if not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH SHADY GROVE ADVENTIST HOSPITAL DIRECTOR ROCKVILLE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY GAITHERSBURG permit. 10e. STREET AND NUMBER FUNERAL tof. ZIP CODE 20729 BELL BLUFF ROAD funeral director, page 5 should be detached for use as the burial-transit 20879 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? t YES 2 THO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-FORCES? t YES 2 NO 1 Never Married 2 📉 Merried If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 - YES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPUTER PROGRAMMER 4 COMPUTERS 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surneme) BERNARD E. GARDNER EDNA H. HUTT 8 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LAURA S. GARDNER (WIFE) 20729 BELL BLUFF ROAD-GAITHERSBURG, MD. 20879 pe 20b. PLACE AND DATE OF DISPOSITION (Name ON ORBECK/ 20c. LOCATION -- City or Town, State DATE 1 M Buriel 2 Cremetion 3 1 4 Donation 5 Other (Specify) must JUDEAN MEMORIAL GARDENS 8/24 OLNEY, MARYLAND medical examiner 21. SIGNATURE OF ELIMINAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, ahock, or haart fallura. List only one cause on each line. n and completely filled in to burial, cremation, or IMMEDIATE CAUSE (Final disease or condition Lung Cancer Netastatic law requires that the death certificate be executed within as been signed by the attending physician and completely bet, of Health and Mental Hygiene prior to burial, cremater. resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): . Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? shows any 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🕱 PHYSICIAN: UNCERTAIN [has be 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one HOSPITAL OR ATTENDING PHYSICIAN: The Hem certificate I HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF OEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked, this c 1 Natural 5 Pending М 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, ferm, streel, lactory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 COMPLETED 6 Could not be DIRECTOR: after 28 i 4 Homicide determined hours Item CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 ho 2 ___ MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 295. SIGNATURE AND TITLE OF BE 26c. LICENSE NUMBER 2

37. MIGHTANN'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

M.D. 9707 Medica

| _ | 2 |
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| | law requires that the death certificate be executed within 24 |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | HOSPITAL DR ATTENDING PHYSICIAN: The IN |
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THE HOSPITAL (THE FUNERAL C filed within 72 h TO THE HOSPITA
TO THE FUNERAL
De filed within 7.
IMPORTANT: 1 ITEM: 19b, PER INFORMANT FILM G-728 10/5/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 · STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Victor Ingersoll 2. DATE OF OEATH Gruber August 21, 1995 6:00 P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS 1 M 2 F 94 YRS. Sept.19,1900 716-01-2223 Pennsylvania 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Springbrook Adventist Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Montgomery Silver Spring TX YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2403 Birch Drive 20910 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

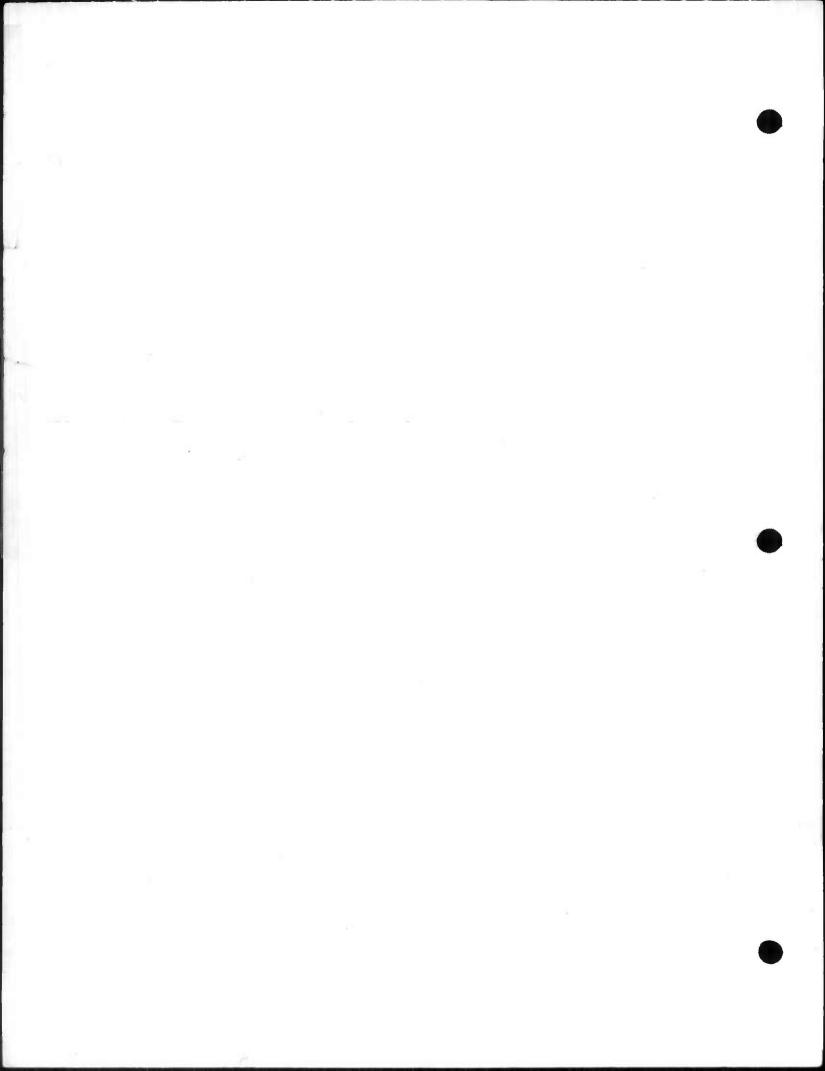
1 ☐ YES 2 ☑ NO Specify: FORCES? 1 YES 2 NO 1 Never Married 2 Married Specify 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Government Administrator Federal Government 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Henry Oscar Gruber Cohn Bella 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Nymber of Fural Floyle Nymber City or Town, State, Zio Code)

5111 MONTROSE RD. # 1011 ROCKVILLE, MD. 20852 Lillian R. Gruber 20910 20a. METHOD OF DISPOSITION
1 [XBuriel 2] Cremation 3] Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Judean Memorial Gardens 8/25/95 Olney, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil.Spr., MD 20901 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. interval Betw **IMMEDIATE CAUSE (Final** Onset and Death disease or condition . Metastatic Cancer to Brain Years resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{Q}}}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER:
4X Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 X NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d DESCRIBE HOW INJURY OCCURED 1 25 Natural м 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suleida 6 Could not be 4 Homicide 29e. CERTIFIER

(Check nniv. 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(a) and manner ea stated. 2 MEDICAL ENAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) D 08089 ▶August 22, 1995

11120 New Hampshire Avenue Silver Spring, MD 20904 Michael E. Leibowitz, M.D. 32 REGISTRAR'S SIGNATURE Jalia Davelson Rordall

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



924 South

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

U.S.A

Specify:

14. RACE - American Indian, Black, White, etc.

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

1 TYES 2 TONO

White

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE QF DEATH?

YES 2 NO

29d. DATE SIGNEO (Mojeth, Day, Year)

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8 21 Interval Between

Onset and Death

8. BIRTHPLACE (State or Foreign

6:05 p

Carolina

REG NO

2. DATE OF DEATH

AUGUST

FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

A SOCIAL SECTION NUMBER

DONALD BERNARD GAYNOR

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7. DATE OF BIRTH (Month, Day, Year) 579.20.9379 TX M 2 1 YRS. 70 Sept.27 Pages 1, 2, 3 should Sa. FACILITY NAME (If not Institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR National Institutes of Health Bethesda RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Jefferson W.V. Charles Town permit. FUNERAL 10s. STREET AND NUMBER Rt. 4 Box 260 Cattail Rd. funeral director, page 5 should be detached for use as the burial-transit 25414 retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1X YES 2 NO IF YES, GIVE WAR OR DATES WWII 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rica 1 TYES 2 NO BY Specify 3 Widowed 4 Divorced 16a. OECEOENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) +3 Executive Director AFTRA 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Reuben Goldstein BE Dorothy Chensman notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy Gaynor Rt. 4 Box 260 Cattail Rd. Charles Town, W.V.25414 Page 6 may be Pe 20g METHOD OF OISPOSITION

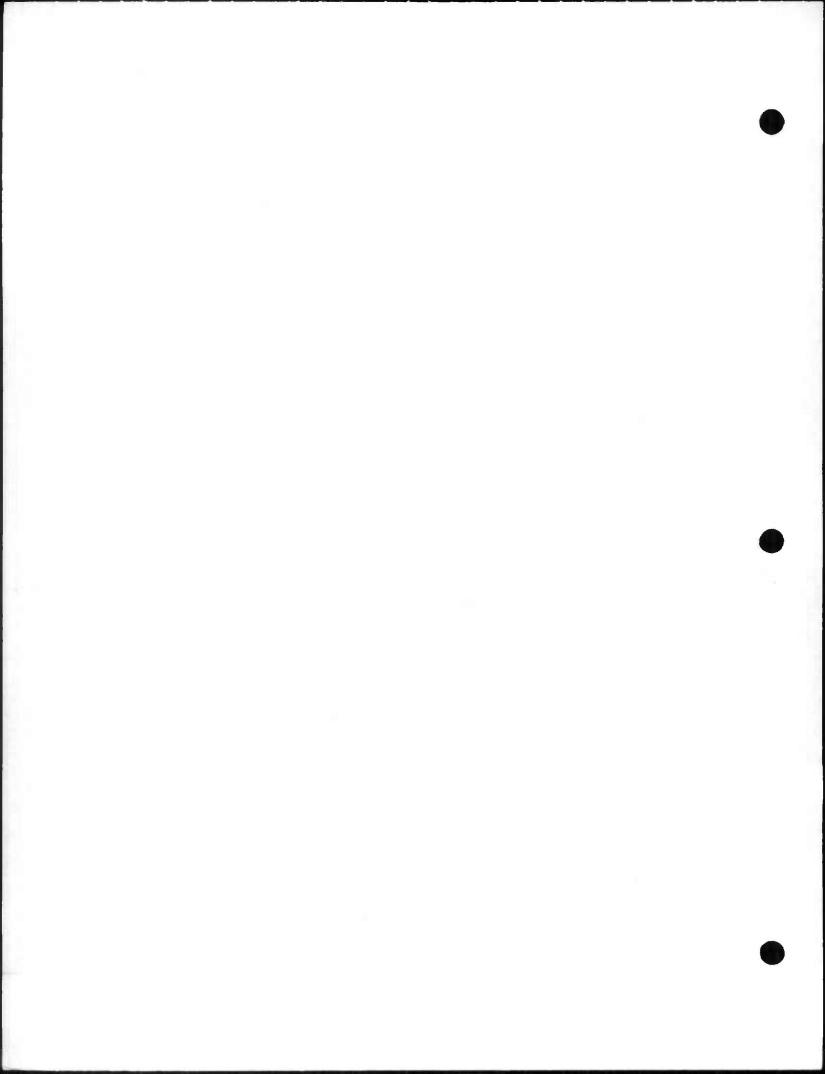
1 ABuriel 2 Cremetton 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must cemelary crematory or other place) Arlington National Cemetery 8/24Arlington, Virginia 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Joseph Gawlers Sons 21. SIGNATURE OF FONERAL SERVICE LICENSEE examiner death. each 5130 Wisconsin Ave. N.W. Washington D.C. 24 hours after de filled in by the fu on, or removal. medical 23. PART-1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6 IMMEDIATE CAUSE (Finel cremation, the disease or condition INTRACEREBRA HEMORRHAGE HEMISPHERIC mpletely resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): and com PARASAGITAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 if any, leading to immediate prior 1 HRONIL cause. Enter UNDERLYING CAUSE (Disease or injury LYMPHOCI other t attending phy-OUE TO (OR AS A CONSCOUENCE OF): that initiated events resulting in death) LAST 0 the atter injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? by t shows any signed | YES 2 NO of P DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) Hem certificate I OSPITAL OTHER: 1 YES 2 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 9 27. MANNER OF GEATH 26e. OATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, with with 1 Natural
2 Accident 1 YES 2 NO BY After t 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) -3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: Abours after citem 28 Is 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my kno riedge, death occurred at the time, date end place, end due to the cause(s) and menner ee stated. TO THE HOSPITAL TO THE FUNERAL OF See filed within 72 h 2 MEDICAL EXAMINER: On the basis ation and/or investigation, in my opinion, death occured at the time, data end place, end due to the cause(e) and menner es stated. 296, SIGNATURE AND TITLE OF GERTIFIER 29c. LICENSE NUMBER ulanto 60 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NICHOLAS THEODORE, M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 31. DATE FILEO (Month, Day, Year)
AUG 23 1995 32 REGISTRAR'S SIGNATURE Julia Davelson Revolate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR | IF UNDER 24 HRS.

6. AGE (In yrs. last birthday)

OHMH. 15 Rev 1/89



| BALTIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | filled in by the funeral director, page 5 should be detached for use as the burial-transit p. | he medical examiner must be notified at once. |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit p be filed within 72 hours after death with the State Dept. of Reath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

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ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

6.

AUG 23 1995

31. DATE FILED (Month, Day, Year)

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Donald hlter rardner August 21 5:40 PH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Forei DAYS HOURS 1 X M 2 - F 141-26-5252 YRS. Dec. 28. New Jersey Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg 1 YES 2 X NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 18615 Nuthatcher Lane 20879 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 🏋 YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: RACE — American Indian, Black, White, etc. 1 Never Married 2 K Married BY Specify: 3 Widowed 4 Divorced Korean White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Production Manager Soft Drink Company 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Herbert Joseph Gardner BE Jenny Isabelle Shaffer 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Phyllis L. Gardner 18615 Nuthatcher Lane, Gaithersburg, Maryland 20879 must be 20a. METHOD OF DISPOSITION

1 XX Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State cometery, cremetory or other place) Parklawn Memorial Park 4 Donation 5 Other (Specify) 8/24 Rockville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E.Deer Park Dr., Gaithersburg, MD. 20877 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) WERNCHON event. DUE TO (OR AS A CONSEQUENCE OF): COROVAN traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a, WAS AN AUTOPSY PERFORMEO? 1 TYES 2 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 X YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Sessidence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Matural 2 Accident 1 YES 2 NO BY Investigation 3 Suicide 28a. PLACE OF INJURY — At home, Jarm, street, lectory, office building, atc. (Specify) 28 Is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, end due to the ceuse(a) and manner as stated. 296. SIGNATURE AND TURLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Hugust 21.

32 REGISTRAR'S SIGNATURE

Snown, 9901 Medical Center Drive, Rockville, Maryland 20850

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

bunial-transit Page 6 may be retained by the hospital or attending physician. page 5 should be detached for use as the notified at e the funeral director. examiner medical and completely filled in by burial, cremation, or remo the event. traumatic prior to l signed by the attending physician Health and Mental Hygiene prior to other t 0 Injury, shows any this certificate has been it with the State Dept. of H 23 Item HOSPITAL OR ATTENDING PHYSICIAN: 5 marked, DIRECTOR: After to hours after death v 69 200 item TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 hr

Pages 1, 2, 3 should

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AUG 23 1995

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH t. DECEDENT'S NAME (First, Middle, Lust) 2. DATE OF DEATH MONTH Mary Martha Gordon August 995 4:30 A.M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 St F 245-40-6751 YRS 68 Sept. 10,1926 North Carolina 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Mediplex Nursing Center Gaithersburg Montgomery RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Germantown 1 YES 2 X NO 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21 Pine Ridge Court 20874 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 N NO Specify: ti. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: 3 Widowed 4 Divorced **Black** 18a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Mill Worker Sewing Mill 17. FATHER'S NAME (First, Middle, Lust) 18. MOTHER'S NAME (First, Middle, Meiden Surname) John Quincy Biggers Bertha Gordon 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly M. Wilmore Pine Ridge Court, Germantown, Maryland 20874 20a. METHOD OF DISPOSITION
1 ☐ Burlet 2 ☐ Cremetton 3 № Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State NOOTH CAROLINA 4 ☐ Donation 5 ☐ Other (Specify) GASTONIA. 21 SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home NIS 10 E.Deer Park Dr., Gaithersburg, MD. 20877 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Pneumonia resulting in death) DUE TO (OR AS A CONSEQUENCE OF) b. Anemia Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING . Uterine Cancer CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\sqrta\) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 23 Nursing Home 8 Residence 8 Other (Specify) 1 YES 2 1 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 X Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be 4 Homicide 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the ceuse(s) and manner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and menner as stated. 29c. LICENSE NUMBER THE BY CETY 29d, DATE SIGNED (Month, Day, Year)

R306

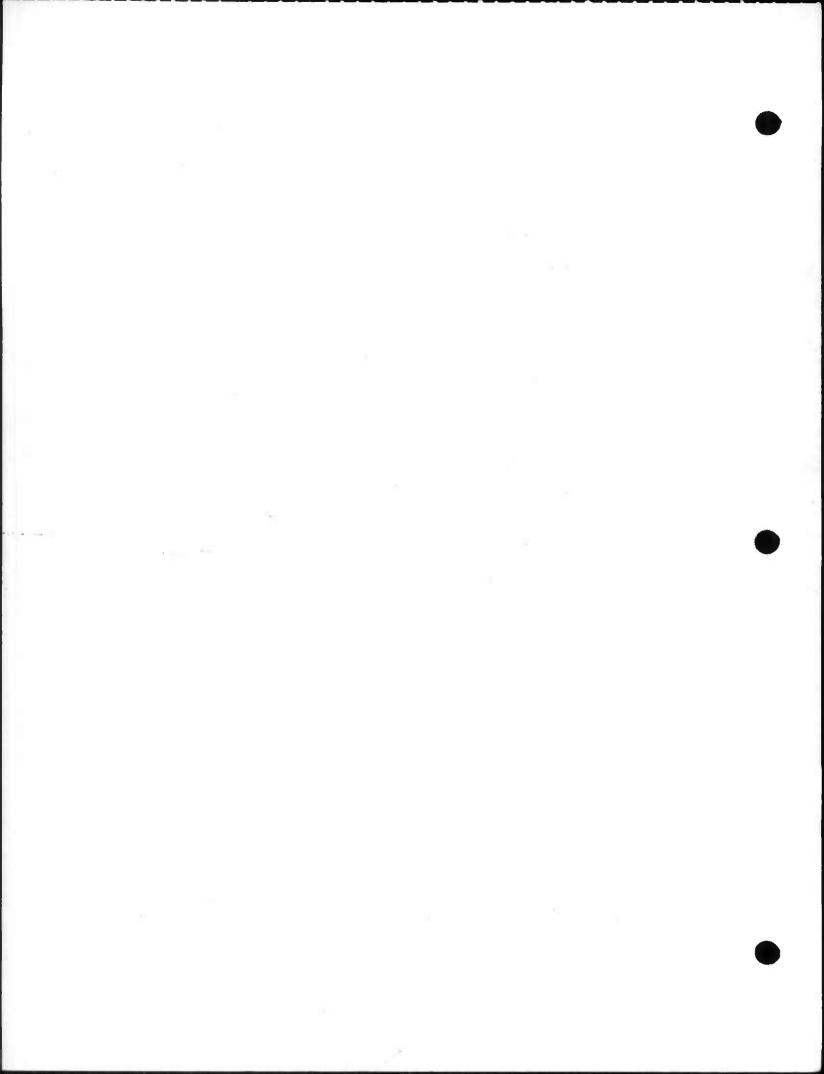
PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Vin Davoles Randall

Gabriel A. Berrebi, M.D., 15200 Shady Grove Road, #305, Rockville, Maryland 20850

August 21, 1995



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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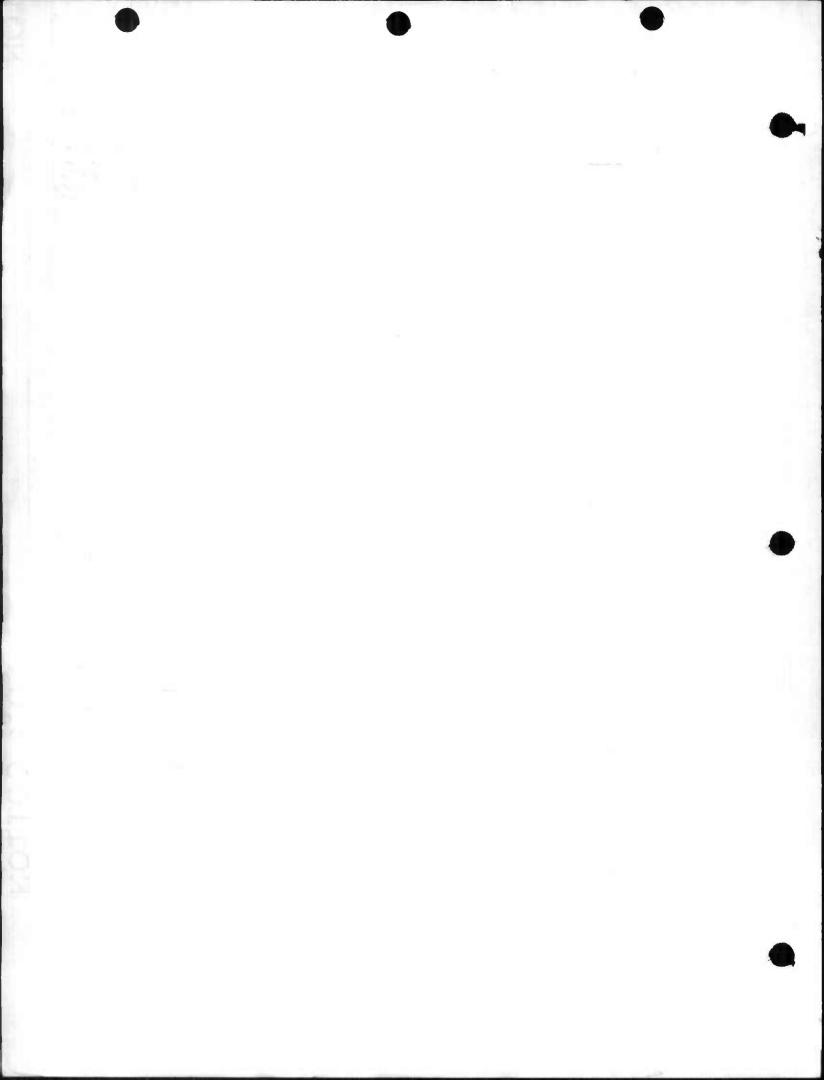
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR

| 1 - STATE REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG. NO |). | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------|----------------------------------------------------------|--------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Leet) | M. G | lennon | | | | DAY YES | |
| 4. SOCIAL SECURITY NUMBER 213 48 4899 8787 | 5. SEX 6. AGE | (In yrs. last birthday) | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 12-31- | 8. B | IRTHPLACE (State or Foreign TRGINIA |
| 90. FACILITY NAME (If not institution, give a HOMEWOOD RETIR. | | | FREDE | ERICK | | 9c. COUNTY | DERICK |
| RESIDENCE OF DECEDENT 100. STATE 100. COUNT FRE | DERICK | | TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO |
| 10e. STREET AND NUMBER 6529 SOUTH CLI | FTON RD. | | 101 | 21703 | | | OF WHAT COUNTRY? S.A. |
| 11. MARITAL STATUS 1 Never Married 2 Married XX Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | 2 NO | If yes, sp | endent OF HISPAI ecity Cuben, Mexica 2 XNO Specifi | HC ORIOIN? (Specify Yen, Puerto Rican, etc.) | - 10 | RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDU (Specify only highest grade Elementary Secondary (0-12) | | 16e. DECEDENT'S US (Give kind of wor Me. Do NOT use if PRINTER | k done during mo etired.) | st of working | 166. KIND OF BUREAU O | SINESS/INDUSTI | aving&PRINT |
| 17. FATHER'S NAME (First, Middle, Lest) CHARLES WARREN | YEATMAN | | | | ME (First, Middle, Maider TA ELLA | | |
| 190. INFORMANT'S NAME (Type/Print) THOMAS GLENNON | | | AS 10 | | Route Number, City or Tox | wn, State, Zip Code | 9) |
| 20e. METHOD OF OISPOSITION XSurtal 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | CATE OF HE | | | | OCATION CHY | ER SPRING, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE 3 | der | | | HOME IN | C 254 C | ARROLL ST N.W. |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b | A CONSEQUENCE OF): A CONSEQUENCE OF): | Vasc | u las | D. Zens. | e | Onset and Death |
| PART II. Other eignificent condition | ns contributing to death | | | g cause given in | | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSBITAL | | | LACE OF DEATH (C) | eck only one) | | |
| 1 res 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Rursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 1 Netural 5 Pending Ne | | | | | | INJURY OCCURE | ED |
| 2 Accident 3 Suicide 6 Could not be 4 Homicide datermined | 2 Accident investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State) | | | | | | |
| 0001 | BICIAN: To the best of my kno | | | | | | use(e) and manner ee stated, |
| 296. SIGNATURE AND TITLE OF CENTIFU | | ~ | 15- | 29c. LICENSE NU D 16428 | | 29d. DATE SIG | SNED (Morith, Day, Year) |
| CASPER E. CLINE | 300 WEST | 9th ST., | | CK, MD. | | / |) |
| S1. DATE FILED (Month, Day, Year) AUG 23 199 | 32. REGISTRAD'S SIG | harve Pardall | | | | | 537 |



| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | | HEALTH AND | MENTAL HYGIE | | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | | TRACY | ROBIN | | | HALL | AUGUST | 17, 19 | 995 10:30 Pm |
| | 1 | 4. SOCIAL SECURITY NUMBER | | in yrs. last birthday) | IF UNDER 1 YEA | | 7. DATE OF BIRTH (Month, Day, Year) | | I. BIRTHPLACE (State or Foreign Country) |
| PI | | 579 90 5303 | 1 🔀 M 2 🗆 F | 32 YRS. | - UAY | s Hooks Mile. | | 1,1963 | WASHINGTON, D |
| 2. 3 should | ECTOR | 9a. FACILITY NAME (If not institution, give some prince georges residence of decement | , | CENTER | | N OR LOCATION OF D | | 9c. COUNT | Y OF DEATH NCE GEORGES |
| es . | EC | 10a. STATE 10b. COUNT | Υ | 10c. CI | TY, TOWN DR LO | CATION | | | 10d. INSIDE CITY |
| ft. Pages | DIR | MD PRIN | CE GEORGES | oxe | ON HILI | L | | | LIMITS? |
| n. ansit permit. | IERAL | 100. STREET AND NUMBER 803 MAURY AVEN | UE #3 | | | 101. ZIP CODE 20745 | | | S.A. |
| 5-0020 nding physician. ss the burial-transit | BY FUN | tt. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 XNO | If yes, | DECENDENT OF NISPA appecity Cuban, Maxic ZES 2 NO Speci | | es or No.— 1 | 4. RACE — American Indian, Black, White, atc. Specify: BLACK |
| Se affe | 윤 | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DECEDENT'S | S USUAL OCCUPY work done during | ATION most of working | 16b. KIND DF BI | USINESS/INDU | |
| D 21 spital or led for | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | CL E | ise retired.) | most of working | PRIVA | TE | |
| # 8 E | BE CO | | AKER | | | GLADY | | L. | |
| be retain ge 5 sho e notifi | 5 | 19a. INFORMANT'S NAME (Type/Print) MRS. GLADYS | COLEMAN | | | | OXON HIL | | |
| 6 may ector, pa | | 20a, METHOD OF DISPOSITION 1 Neural 2 Cremation 3 Fram | oval from State 20b. | RM ONY | OF DISPOSITION | (Name of | | | ty or Town, State |
| | | 4 Donation 5 Other (Specify) | CENSEE | KMUNY | | | 8/24/95 LA | NDOVE | R, MARYLAND |
| r death. | Ш | of m | 1. Ku | dlas | 3200 | R.I.AVE. | ,MT.RAINIE | R,MD. | |
| of within 24 hours after the bompletely filled in by the companion, or remove event, the medical | | 23. PART I. Enter the diseases, or abock, or heert feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Course on ea | the death. Do | - Jon | mode of dying, suc | h as cardiac or resp | | Approximate interval Batween Onset and Death |
| th certificate be execute ending physician and co I Hygiene prior to burial or other traumatic | ERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST | DUE TO (OR AS A C DUE TO (DR AS A | | | | | | |
| that the death ed by the atten th and Mental H | IL C | PART II. Other aignificant condition | ne contributing to deeth bu | ut not resulting | in the underly | ring cause given in | PERFO | RMED? | 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| signed Health | MEDICA | | | | | | 1 YYES | 2 🗌 NO | OF DEATH? |
| law 23 tas | | DID TOBACCO USE CONT | | | | | N 🗆 | | |
| ate ate | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 6. PLACE DF DEA | OTHER: | ne) | | | |
| ICIA) | ₹ | 1X YES 2 NO 27. MANNER OF DEATH | 1 ☐ Inpetient 2 X ER/Outpe 26a. DATE OF INJURY | rtlant 3 DOA | | ome 5 Residence | | | |
| The state of the s | | 1 Netural 5 Pending | (Month, Day, Year) | a O IN | JURY | INJURY AT WORK? YES 2 NO | 28d. OESCRIBE HOW | | REO |
|) 5 4 5 L | D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY | - At home, farm, | | / - | 281. LOCATION (Street | and Number or | |
| OR ATTENI DIRECTOR: nours after tem 28 is | Щ | 4 Nomicide detarmined | building, atc. (Speci | THE | T | | 55 PA | LE C | VERDNE |
| E ZE ZE | COMPLET | | CIAN: To the best of my knowle | | | | | | |
| | | 296. BIGHATUSE AND TITLE OF CERTIFIE | | | 3) - MIL 3 | 29c. LICENSE NUI | | | BONED (Month, Day, Year) |
| THE THE DE THE DE THE THE THE THE THE THE THE THE THE TH | BE (| / And | ~ | | | 1922 122100 | 2 (22) | AUGUS | |
| | 5 | 30. HAME AND ACCRESS OF PERSON WIT | O COMPLETED CAUSE OF DEA | TH (ITEM 27) (You | r, Phint) | 1 0.C. | 1.6. | INUGUS | 24 12, 1223 |
| | | 1 / 1/2010 | Kan 1 | 11 Pop | n Ctro | ot Pol- | timore, | Mary 1: | and 21201 |
| 7) | - 8 | 31. DATE FILED (Month Deg. Mont) | | 1 Pen | II SLIE | er bar | CTHOTE ! | JOT A TO | and Zizui |

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)

Washington, D.C

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify:

White

1 X YES 2 NO

Approximate interval Between

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

Onset and Death

4:35₩

1995

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

was lad

1995

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31. DATE FILED (Month, Day,

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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Dey, Year) 10/3/13 IF UNDER 1 YEAR IF UNDER 24 HRS. 577-01-1489 81 1 - M 2 X F DAYS HOURS YRS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give etreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince George Hospital Center Cheverly Prince George 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Prince George's Maryland Forestville FUNERAL 10e STREET AND MUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? be detached for use as the burial-transit 2100 Brooks Dr. Apt. 217 20747 USA retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or 1 Never Married 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) BY 3 🕅 Widowed 4 🗌 Divorced 1 TYES 2 THO Specify: COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ementary/Secondary (0-12) 12th College (1-4 or 5 +) Telephone Operator C&P Telephone 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumerne) Leo C. Streitberger H Deborah Dixon Ewin BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Deborah Dorr 12 Shorewalk Dr. Riva, Md. 21140 Page 6 may be 2 20. METHOD OF DISPOSITION
1 M Buriel 2 Cremetion 3 Removal from 14 Donation 5 Other (Specify)
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Cedar HIII The Cemetery 8/25/95 Suitland, Md. 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home examiner hours after death. ala 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 n and completely filled in by the to burial, cremation, or removal, medicai 23. PART LEnter the diseases/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. **IMMEDIATE CAUSE (Final** the disease or condition_ Cardiopselar executed within event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, has been signed by the attending physician : Dept, of Health and Mental Hyglene prior to n 23 shows any Injury, or other traum if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL that 1 TES 2 0000 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \boxtimes UNCERTAIN \square PHYSICIAN: ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item DIRECTOR; After this certificate I hours after death with the State Item 28 is marked, or Item HOSPITAL: OTHER: 1 TES 2 THO 1 Schopetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending investigation 1 YES 2 NO м BY 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide determined OR 290. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. COMPL HOSPITAL FUNERAL ((Check only one) 30 TO THE HOSPITA
TO THE FUNERAL
FINE WITH 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occursed at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE-AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 800 20 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Talia Davideor Rardall

Hanover Ackway

C.

HART

CATHERINE

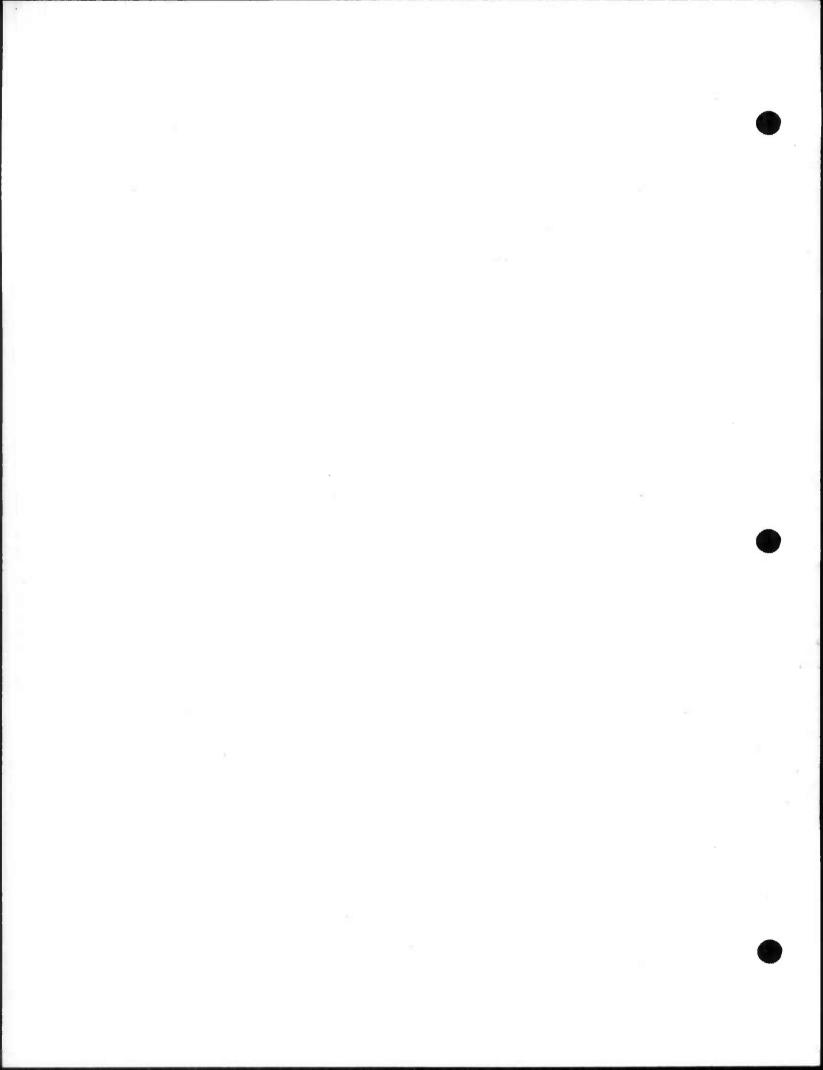
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2. DATE OF DEATH

20

AUGUST



ITEMS: 23 PART I, II, 27, PER MEO FILM G-727 9/16/95 t.t

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| REGISTRAR | | | | | | | | | | | |
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| 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | MONTH | OF OEATH | AY | YEAR | 3. TIME OF D | |
| BETTY JEAN | N HAF | RRIS | | | | AUGU | ST 15 | Š, 1 | 1995 | 0450 | 0 A |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | | ER 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | 8. BIRT | HPLACE (State of | or Foreign |
| 577-64-2634 | t M 2 XF | 46 | YRS. MONTH | | HOURS MIN. | Augu | | | | hington, | D.C. |
| 5505 JOEL LANE | street and number) | | | | DE HILL | | | | | E GEO | RGES |
| 10s. STATE 10b. COUNT | | | toc. CITY, TOWN | | | | | | | 10d. INSIDE (| |
| District of Co | lumbia | | | | ashingto | n | _ | T.o. or | 7,751,05 | 1 X YES 2 | - |
| 623 M St., N. | Ε. | | | 10 | | 002 | | | | States | |
| tt. MARITAL STATUS t X Never Married 2 Married 3 Widowed 4 Divorced | t2. WAS DECEDENT FORCES? t IF YES, GIVE WI | YES 2 N | | If yes, sp | cendent of Hispa pecify Cuben, Mexic S 2\(\sum \text{NO}\) Speci | an, Puerto F | | s or No- | | CE — American ck, White, etc. city: Blac | |
| ts. DECEDENT'S EOU | | téa. OE | CEOENT'S USUAL | OCCUPATI | ON | 16b. | KINO OF BU | ISINESS/IN | NOUSTRY | | |
| (Specify only highest grade Elementary/Secondary (0-12) 1 Oth | College (1-4 or 5+) |) (Gi | ive kind of work dor Do NOT use retired | o during mi One | ost of working | | | | N/A | | |
| 17. FATHER'S NAME (First, Middle, Lest) | | | | One | ts. MOTHER'S NA | AME /Eint A | Airtella Mairian | | | | |
| | ph B. Har | rio | | | te. MOTHER S N | | ie Ja | | | | |
| | pn b. nar | | | | | | | | | | _ |
| 19a. INFORMANT'S NAME (Type/Print) Wanda Harris | | 196 | | | end Number or Rural | | | | | 2220 | 2 |
| 200. METHOD OF DISPOSITION | | | | | | _ | E 20c. LC | | | |) |
| | novel from State | cemetery cres | AND DATE OF DISP | al la | | 8/19/9 | | | | ver, Md | |
| 1 X Burlal 2 Cremation 3 Ren 4 Donation 6 Other (Specify) | TOVAL HOILI STATE | Harr | mony Men | ioria | LIGIK | 01 -010 | _ | | | | |
| 1 A Burlai 2 Cremation 3 Ran 4 Denation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI 23. PART Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition | CENSEE Complications that List Dnly Dne caus | t deused the de | mony Men | 4001 or the mo | Benning | Rd., | Stewa N.E. | rt F Was | uner | Appro | e 2001 ximate |
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

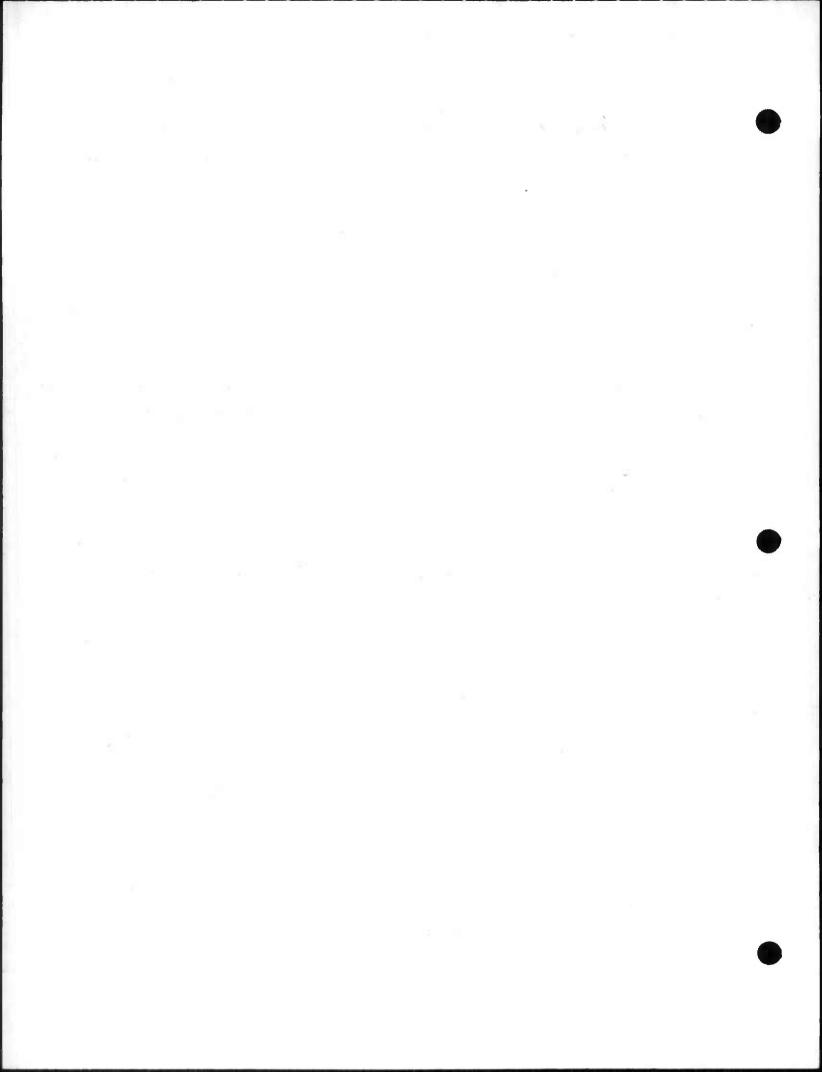
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 **DIVISION OF VITAL RECORDS, P.O. BOX 68760**

AUG 23 1995

OHMH-16 Rev 1/89

2 × 10

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH HUGUST 22 - 1995 30 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. BIRTNPLACE (State or Foreign Country) 1 🗌 M 2 💢 F 91 578-58-8643 YRS. September 1, 1903 New Jersev Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR KERN MANYIMO HOSPITAL GEORGE 10b. COUNTY 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY Fort Washington Maryland Prince George's 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 20744 USA 9606 Traverse Way funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerto Ric 1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Wildowed 4 Divorced Black. ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) COMPL Home Maker Private 6 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Sumame) John Gibson 70 Caroline Nickens BE Unknown notified 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9606 Traverse Way, Ft. Washington, MD 19s. INFORMANT'S NAME (Type/Print) 2 20744 James Hicks, Jr. 2 20e, METHOD OF DISPOSITION
1 A Burlal 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 Donation 5 Other (Specify) National Cemetery Arlington, Virginia examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD attending physician and completely filled in by the intell Hygiene prior to burial, cremation, or removal. 20785 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each IMMEDIATE CAUSE (Fine) Onset and Death disease or condition resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 **OUE TO (OR AS A CONSEQUENCE OF** traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONS If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atter PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY 1 TES 2 NO OF DEATH? 1 TYES 2 T NO L of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has be OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? certificate h HOSPITAL OTHER: ent 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) this cu 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY After death 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28 is i 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: / 4 Homicide 29a. CERTIFIER TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho wiedge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Mo 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (Type, PRINT) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 27) (TYPE, TYPE) & GARANTON AND ADDRESS OF DEATH (ITEM 2



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | | | Merce | 3. TIME OF DEATH |
|-------------------------------------------------------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------|-----------------------------|---------------|--------------|----------------------|-------------|-------------------------------|--------------|--------------|-----------------------------|--------------------------------------------------------------|
| | | MICHAEL CALV | | SHES | | | | | | AUG. | 4 | 199 | 95 | 12:35 A* |
| Should | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs | | IF UNDER 1 | YEAR DAYS | IF UNDER | MIN. | 7. DATE OF I | ly. Year) | | 8. BIRTH Country | PLACE (State or Foreign |
| | | 220-52-8730 9a. FACILITY NAME (If not Institution, give s | 1 M 2 F | 47 | YRS. | Di ATU | DOMAS - | | | JULY | 17, | | | ARYLAND |
| (C) | OR | KNAPPS NARROWS | , | | | 1 | | OR LOCATION | | ATH | | | ALBO | |
| 1. 2, | 151 | RESIDENCE OF DECEDENT | | | | | | | | | | 112 | TIBO | |
| nit. Pages | DIRE | | вот | | 10c. CIT | SHEI | | | | | | | 1-4 | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| nsit permit. | ERAL | 100. STREET AND NUMBER 21455 DONNELL | JONES F | STD | | | 101 | 7. ZIP CODE 216 | | | | 10g. CITI | USA | THAT COUNTRY? |
| 215-0020 attending physician. se as the burlal-transit | BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 | ARMED | H | yes, sp | | n, Mexican | C ORIGIN? (S , Puerto Rica | | or No— | 14. RACE Black Specif | - American Indien, , White, etc. |
| | ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 160. | DECEDENT'S (Give kind of | work done du | UPATIO | ON ost of working | a | 16b, KIN | D OF BUS | INESS/IND | USTRY | |
| 5 5 | LET | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | life. Do NOT u | se retired.) | | out of World | | | | | | _ 0 |
| AND the hospital detached to once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | 4 | | OW | NER | | 18 MOTH | IED'S NAM | IE (First, Midd | | SER | VIC | E |
| 3 8 S | BE C | JOHN GORDON | HUGHES | | | | | The same of | | E M. | | | T. | |
| MAR retained to 5 should | 0 B | 19e. INFORMANT'S NAME (Type/Print) | | | | | | and Number | or Rural Ad | oute Number, (| City or Town | , Stete, Zip | Code) | |
| .r & & e | - | PATRICIA E. HU | GHES | | | | | | SANT | LANI | | | | ICHAELS, MD |
| e 6 m ector, | | 20e. METHOD OF DISPOSITION 1 Burlel 2 Tormellon 3 Rem 4 Donation 6 Other (Specify) | | | SBUR | | | | Z | 8-5 | | ISBU | • | |
| | | 21. SIGNATURE OF FUNERAL SERVICE LIE | ERSEE O | 1.4 | 0 | ME | WN. | AM F | S OF FAC | RAL E | IOME. | . P. | Α. | |
| | | D. Kent | Mysp | 7 | 2FSP | 20 | 0 | S. H | ARR | ISON | ST. | , EA | STO | N, MD |
| S = 5 | | 23. PART I. Enter the diseases, or o shock, or heart failure. | complications that List only one cau | t caused the | death. Do i | not enter t | ne mo | de of dyli | ng, such | as cardiac | or reapli | ratory arr | est, | Approximata Interval Between |
| filled tion, or the m | | IMMEDIATE CAUSE (Final disease or condition | 7- | , | | | | | | | | | | Onset and Death |
| ted within 24 completely fill ial, cremation, event, the | | resulting in desth) | OUE TO | ON AS A CON | SEQUENCE O | F): | | - | | | | | | IMMEDIATE |
| B 20 20 | z | | - | Lua | 1 | , | | | | | | | | Minutes |
| | RTIFICATION | Sequentially list conditions, if any, leading to immediate | | (OR AS A CON | SEQUENCE O | F): | | | | | | | | |
| | | CAUSE (Disease or injury | DUE TO | (OR AS A CON | SEQUENCE O | D. | | | | | | | | |
| eath certifica attending phy trai Hygiene y, or other | E | that initiated events reaulting in death) LAST | 4 | (OII AS A COII | SECOENCE O | r). | | | | | | | | 1 |
| 7 0 0 5 | Ë | PART II. Other significant condition | e contribution to | double but a | | | | | | | | | | |
| Y = 55 - | EDICAL | THE OWNER OF THE CONTROL OF THE CONT | e continuating to | death but no | resulting | in the uno | eriying | g cause g | iven in P | Part I. 24e | PERFORI | | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| signed Health | 9 | | | | | | | | | - 10 | YES 2 | M NO | - 1 | OF DEATH? |
| Pred been of she | N. N. | DID TOBACCO USE CONTR | RIBUTE TO CA | USE OF DI | EATH YE | S 🗆 N | 0 [| 1 UNC | ERTAIN | | | | | 1 Nes 2 No |
| P | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | ACE OF DEAT | TH (Check on | _ | | | | | | | |
| SICIAN: The certificate the the State of the State of them | HYSI | 1 TO YES 2 NO | HOSPITAL: | | 3 DOA | OTHER: | g Hom | e 5 🗆 Res | sidence 6 | COther (Sp | ecify) | | | |
| 를 돌돌 등 C | ۵. | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF (Month, De | ny, Year) | 26b. TIM | E OF 2 | WO | URY AT | | 28d. DESCRIE | BE HOW IN | JURY OCC | URED | |
| VDING VDING After death | BY | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE O | 95 FINJURY - AI | home, farm, r | | | YES 2 | | 261. LOCATIO | -47C | nd Number | 125 | de |
| ATTEN CTOR: after | TED | 4 Homicide Could not be | Bri | etc. (Specify) | | , | , | | | City or To | wn, Stete) | NO | | 25 Tildymuan |
| OR OR | MPLE | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC | | | death occurre | ed at the tim | e, date | end place. | end due to | | - | | | U.S. , Wahrman |
| TO THE HOSPITAL TO THE FUNERAL Se filed within 72 IMPORTANT: # | COM | one) 2 MEDICAL EXAMINE | R: On the beste of ex | emination end/ | or investigation | n, in my opi | nion, de | leath occurs | d at the ti | me, date end | piece, end | due to the | cause(e) | end menner ee stated. |
| HE HO | ш | 29 SIGNATURE AND TITLE OF STREET | _ | | | | | 29c. LICE | NSE NUME | BER | | 29d, DATE | SIGNED | (Month, Day, Year) |
| TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h | 0 8 | | D | | | | | D | 247 | 769 | | Þ 8 | 2-4 | 1-95 |
| | - | 30. NAME AND ADDRESS OF PERSONAITH | | | | | | | | | | | | |
| i | | L. THOMAS DIVIL 31. DATE FILED (Month, Day, Year) | LO, M. D | R'S SIGNATION | 4 MA | KVEL | CO | URT, | EA | STON, | MD | 216 | 01 | |
| | | AUG - 7 1995 | Sa REGISTRA | election | blall | | | | | | | | | |

• pater or a second

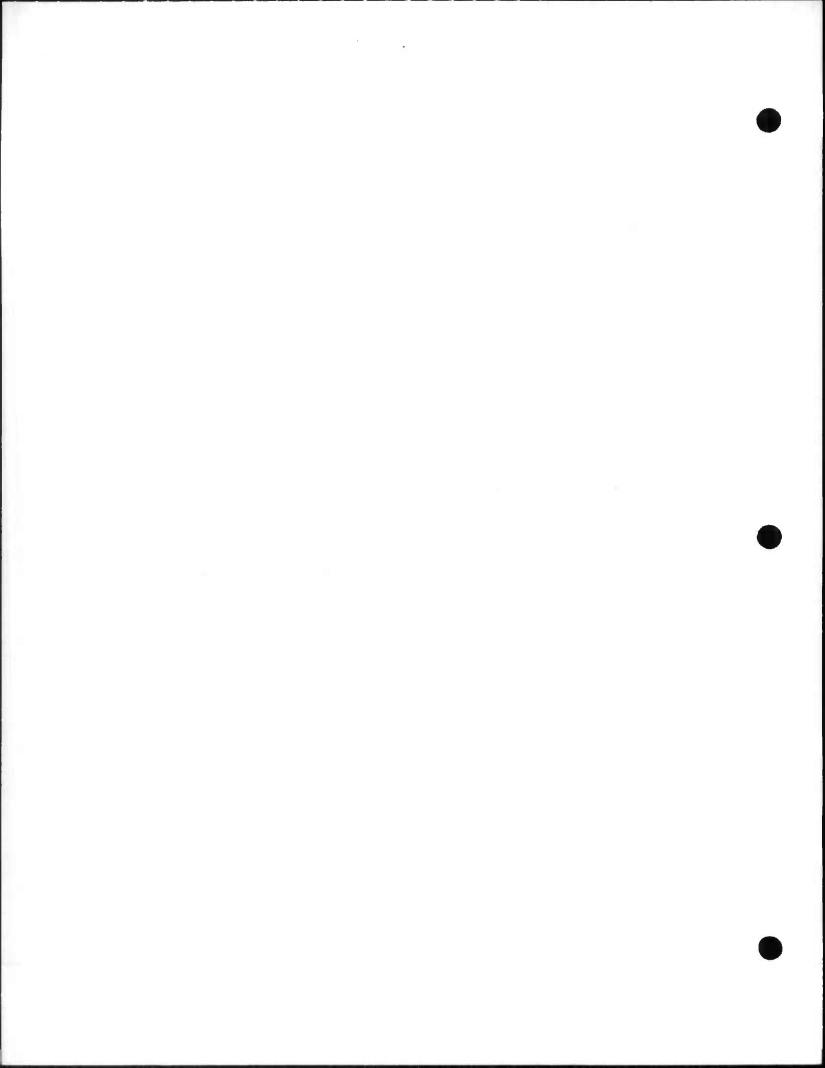
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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | 1 - STATE REGISTRAR | CERTIF | ICATE OF | DEATH | REG. NO | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------|---------------------|-----------------------------------------------------|--------------------|------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF GEATH | | 3. TIME OF DEATH |
| | Wilimina Holla | nd | | | August 3 | 1995 | 10:15 AM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE | In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | e. BIR | ITHPLACE (State or Foreign |
| | 213-24-1607 1□M2以F | 63 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 10/09/3 | l Mar | yland |
| | 9s. FACILITY NAME (If not institution, give street and number) | | 96. CITY, TOWH | OR LOCATION OF D | EATH | 9c. COUNTY OF | |
| O. H | Meridian - The Pines | | F | aston | | Тај | bot |
| DIRECTOR | RESIDENCE OF DECEDENT 108. STATE 108. COUNTY | | | | | | |
| E . | Maryland Caroline | toc. CIT | Y, TOWN OR LOCA | | + | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | | Pres | ton | | 1 YES 2 NO |
| RA | | | 10 | f. ZIP CODE | | | F WHAT COUNTRY? |
| FUNERAL | 4502 Box 3 Nelpine Road | | | | 655 | | States |
| | 1 X Never Married 2 Married FORCES? 1 YES | 2 NO | If yes, sp | ecify Cuban, Maxic | NIC ORIGIN? (Specify Yea an, Puerto Rican, atc.) | or No- 14. RA | CE — American Indian, ack, White, atc. |
| i i | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DA | ATES | 1 🗆 YES | 2 XNO Speci | fy: | Sp | ec#y: Black |
| 0 | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S | USUAL OCCUPATION | ON | 16b. KINO OF BUS | SINESS/INDUSTRY | |
| H | Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT us | work done during mo se retired.) | ost of working | | Water allow | |
| AP. | Tenth | Domest | ic Work | ter | Privat | e Home | S |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | AME (First, Middle, Maiden | Surname) | |
| ш | Leroy Holland, Sr. | | | Lilli | an Thomas | 3 | |
| TO B | 19a, INFORMANT'S NAME (Type/Print) | | | | Route Number, City or Tow | | 21655 |
| F | Vanessa Jordan | 4502 | Bx 3 N | Velpine | Rd. Lot | 3, Pre | ston, MD |
| | | PLACE AND DATE | | ame of | DATE 20c. LO | CATION — City or | Town, State |
| | 4 Donation 8 Other (Specify) | t. Zio | n Cemet | | | hlehem | , MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | ND ADDRESS OF FA | | ow Fun | eral Home |
| | Michael 7. Esken | | | | Federalsh | | |
| | 23. PART I. Enter the diseases, or complications that caused shock, or heart fellure. List only one cause on experience. | the deeth. Do r | not enter the mo | de of dying, suc | th as cardiac or reapi | ratory arreat, | Approximate |
| | IMMEDIATE CAUSE (Finel | ech line. | | | | | Onset and Death |
| | disease or condition resulting in death) | 14 | | | | | 15mm |
| | | CONSEQUENCE OF | P: 1/ | / | 0 | | |
| 8 | Convendable that conditions | resclint | or VA | On | リノモ | | 20 /20 |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | CONSEQUENCE OF | on d | On | | | , |
| [윤] | CAUSE (Disease or injury | CONSEQUENCE OF | 0- (- | 0010 | | | |
| Ē | resulting in death) LAST | | ,. | | | | i 1 |
| 핑 | d | | | | | | |
| DICAL | PART II. Other algorificant conditions contributing to deeth be | ut not recuiting | in the underlying | g cause given in | Part I. 24a, WAS AN PERFOR | | 4b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO |
| 음 | NIDOM | | | | 1 🗀 YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| ME | J+ TW | | | | | | 1 YES 2 NO |
| ä | DID TOBACCO USE CONTRIBUTE TO CAUSE O | F DEATH YE | S NO | UNCERTAI | N 🗆 | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF DEAT | OTHER: | | | | |
| YSI | 1 YES 2 NO t Inpetient 2 ER/Outp. | ntlent 3 DOA | | e 5 🗆 Residence | 8 Other (Specify) | | |
| | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIMI INJ | | URY AT | 28d. DESCRIBE HOW II | NJURY OCCUREO | |
| BY | 2 Accident Investigation | | | YES 2 NO | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | — Al home, farm, s | streat, factory, offic | • | 281. LOCATION (Street a City or Town, State) | and Number or Rura | l Route Number, |
| COMPLETED | AN APPRINT | | | | | | |
| P | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge one) | | | | | | |
| Ö | 2 MEDICAL EXAMINER: On the basis of examination | and/or investigation | n, in my opi <i>n</i> ion, d | eath occured at the | time, data and place, an | d due to the cause | e(s) and menner as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUI | | 29d. DATE SIGNE | D (Month, Day, War) |
| TO B | 14 & Suran | - PD | | 04281 | 6 | ▶ 8/2 | /4 - |
| F | 30, NAME AND ADDRESS OF PERSON WAS COMPLETED CAUSE OF DEA | | | | | | 24 |
| H | | | nman's | Lane | Easton, M | 1D 2'16 | 01 |
| | 31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNA ALIC - 1 1995 | TUPS | | | | | |
| - 1 | ALIG - 4 1995 Julia d'avoles | | | | | | 1 |

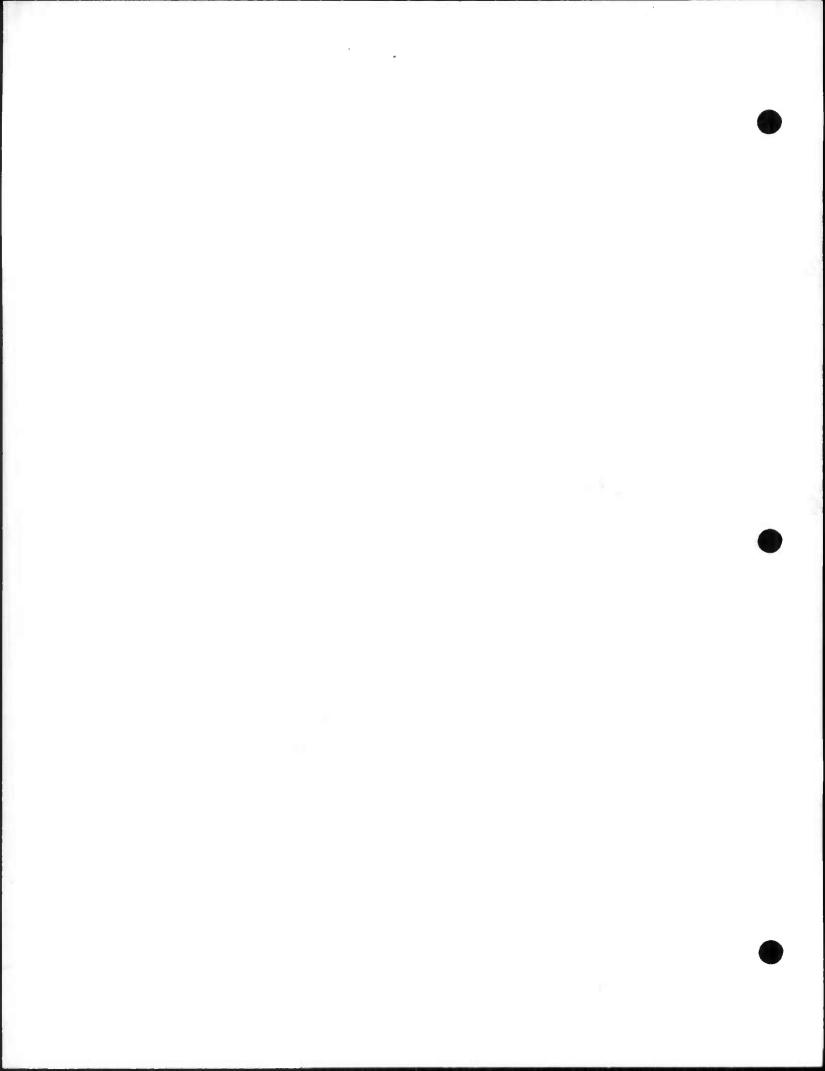


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| THE HOSP | THE FUNE | MPORTANT | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF HEALTH | | ITAL HYGIENI | E | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | - | | DATE OF DEATH | Y YEAR | 3. TIME OF DEATH | |
| | ALLEEN 4. SOCIAL SECURITY NUMBER | D. S. SEX S. AGE / | HALL 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HMS | | | AUG. 11 | 1995 | 6:10 AM M | |
| | | 1 □ M 2 X F 64 | | MONTHS DAYS HOURS | MIN. J | JLY 30, | 1931 | MARYLAND | |
| ~ | 9s. FACILITY NAME (If not institution, give street and number) | | | b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | | | |
| D. | 9541 BLACK DOG ALLEY | | | EASTON | EASTON | | | T | |
| HE | 9541 BLACK DOG ALLEY RESIDENCE OF DECEDENT 106. STATE 106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION EASTON | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | MARYLAND TALBOT EAS' | | | ASTON | STON 101. ZIP CODE | | | 1 TYES 2 NO | |
| FUNERAL | 9541 BLACK DOG ALLEY | | | 1111 - 111 | 21601 | | | USA | |
| FUN | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | VU.S. ARMED | 13. WAS DECENDENT O | F HISPANIC OF | RIGIN? (Specify Yes | or No- 14. RA | CE — American Indian, ack, Whita, etc. | |
| B | 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES | | | 1 YES 2 NO Specify: | | | Specify: WHITE | | |
| 日日 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | NURSES | e retired.) | | NURSIN | с номе | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | HER'S NAME (F | irst, Middle, Maiden S | | | |
| BE (| | | | | | MA R. PERRY | | | |
| 2 | JACK C. HARRIS | | | AODRESS (Street and Number BLACK DOG | | | | 21601 | |
| | 20a METHOD OF DISPOSITION 1 A Burlal 2 Cremetion 3 Ramov | | PLACE AND DATE O | F DISPOSITION (Name of | 1 | | ATION — City or | | |
| | 4 Donation 5 Other (Specify) | | RING"H | LL CEMETE | | | | D 21601 | |
| | M L A | THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW | ESP. | NEWNAM | | | | | |
| - | 23. PART I. Enter tha diseases, or col | W - | | 200 S. I | | | | | |
| 7 | shock, or heart fallure. List IMMEDIATE CAUSE (Final | st only one cause on er | ech ilna. | or entar the mode of dyr | ing, such as | cardiac or reapir | atory arrest, | Approximate intervsi Between Onset and Death | |
| | disease or condition resulting in death) a. TWEST COUCEV | | | | | | | 4418 | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| 7 | | | S A CONSEQUENCE OF): | | | | | | |
| TION | Sequentially list conditions, if any, leading to immediate | OUE TO (OR AS A | CONSEQUENCE OF |): | | | | 1 | |
| FICATION | if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | |
| ERTIFICATION | if any, leading to immediata cause. Enter UNDERLYING | | CONSEQUENCE OF | | | | | | |
| AL CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF |); | given in Part | i. 24s. WAS AN A | WTOPSY 2 | Nb. WERE AUTOPSY FINDINGS | |
| AL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF |); | given in Part | i. 24s. WAS AN A PERFORM | AED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH | |
| MEDICAL | if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | n tha undarlying cause g | | PERFORM | AED? | AVAILABLE PRIOR TO | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A contributing to death be | CONSEQUENCE OF ut not resulting in | n tha undarlying cause g | given in Part | PERFORM | AED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO (OR AS A contributing to death be | CONSEQUENCE OF Ut not resulting in F DEATH YE 28. PLACE OF DEAT | n the underlying cause g S NO UNC H (Check only one) OTHER: | ertain [| PERFORM 1 TYES 2 | AED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| AL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTRII 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH | DUE TO (OR AS A contributing to death be BUTE TO CAUSE O | CONSEQUENCE OF Ut not resulting in F DEATH YE 28. PLACE OF DEAT | The underlying cause g S NO UNC H (Check only one) OTHER: 4 Nursing Home 5 Rae OF 28c. INJURY AT | ERTAIN | PERFORM 1 TYES 2 | ÆED? □ NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTRII 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation | BUTE TO CAUSE O | CONSEQUENCE OF Interpretation of the control of th | n the underlying cause g S NO UNC H (Check only one) OTHER: 4 Nursing Home 5 Re OF 28c. INJURY AT WORK7 1 YES 2 | ERTAIN sidence 6 0 26d. | PERFORM 1 YES 2 | JURY OCCURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
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| D BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) | BUTE TO CAUSE O | CONSEQUENCE OF ut not resulting in F DEATH YE 28. PLACE OF DEAT atlant 3 DOA 26b. TIME inju At home, term, si | n tha undarlying cause g S NO UNC H (Check only one) OTHER: 4 Nursing Home 5 Ra COF 28c. INJURY AT WORK? M 1 YES 2 treet, fectory, office | ERTAIN SIdence 6 0 26d. NO 28t. | PERFORM 1 YES 2 Definer (Specify) DESCRIBE HOW IN LOCATION (Street ar City or Town, State) | JURY OCCURED In No State of Aurantee of A | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | BUTE TO CAUSE O | CONSEQUENCE OF ut not resulting in F DEATH YE 28. PLACE OF DEAT atlant 3 DOA 26b. TIME inju At home, term, si | Treet, fectory, office | ERTAIN SIdence 6 0 26d. NO 28t. | PERFORM 1 YES 2 Definer (Specify) DESCRIBE HOW IN LOCATION (Street ar City or Town, State) | JURY OCCURED In No State of Aurantee of A | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) | BUTE TO CAUSE O | CONSEQUENCE OF ut not resulting in F DEATH YE 28. PLACE OF DEAT atlant 3 DOA 26b. TIME inju At home, term, si | The street, fectory, office In the underlying cause of the underlying the | ERTAIN SIdence 6 0 26d. NO 28t. | PERFORM 1 YES 2 Definer (Specify) DESCRIBE HOW IN LOCATION (Street ar City or Town, State) | JURY OCCURED Id Number or Rurs Her as stated. Idua to the cause | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| E COMPLETED BY PHYSICIAN: MEDICAL | If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | DUE TO (OR AS A contributing to death be BUTE TO CAUSE OF HOSPITAL: Inpatient 2 ER/Outp. 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Speci | CONSEQUENCE OF Interpretation of the control of th | Treet, fectory, office The time, data and place, in, in my opinion, death occur | ERTAIN sidence 6 26d. NO 28t. and due to the ed at the time, | PERFORM 1 YES 2 Definer (Specify) DESCRIBE HOW IN LOCATION (Street ar City or Town, State) | JURY OCCURED Id Number or Rurs Her as stated. Idua to the cause | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO I Route Number, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | DUE TO (OR AS A contributing to death be BUTE TO CAUSE OF HOSPITAL: Inpatient 2 ER/Outp. 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Speci | CONSEQUENCE OF Ut not resulting in F DEATH YE 28. PLACE OF DEATH atlant 3 DOA 25b. Time in At home, term, st edge, desth occurre a end/or investigation ATH (ITEM 27) (Type, | The treet, fectory, office The time, deta and place, a, in my opinion, death occur | ERTAIN sidence 6 26d. NO 28t. and due to the ed at the time, | PERFORM 1 YES 2 Definer (Specify) DESCRIBE HOW IN LOCATION (Street ar City or Town, State) | JURY OCCURED Id Number or Rurs Her as stated. Idua to the cause | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO I Route Number, | |

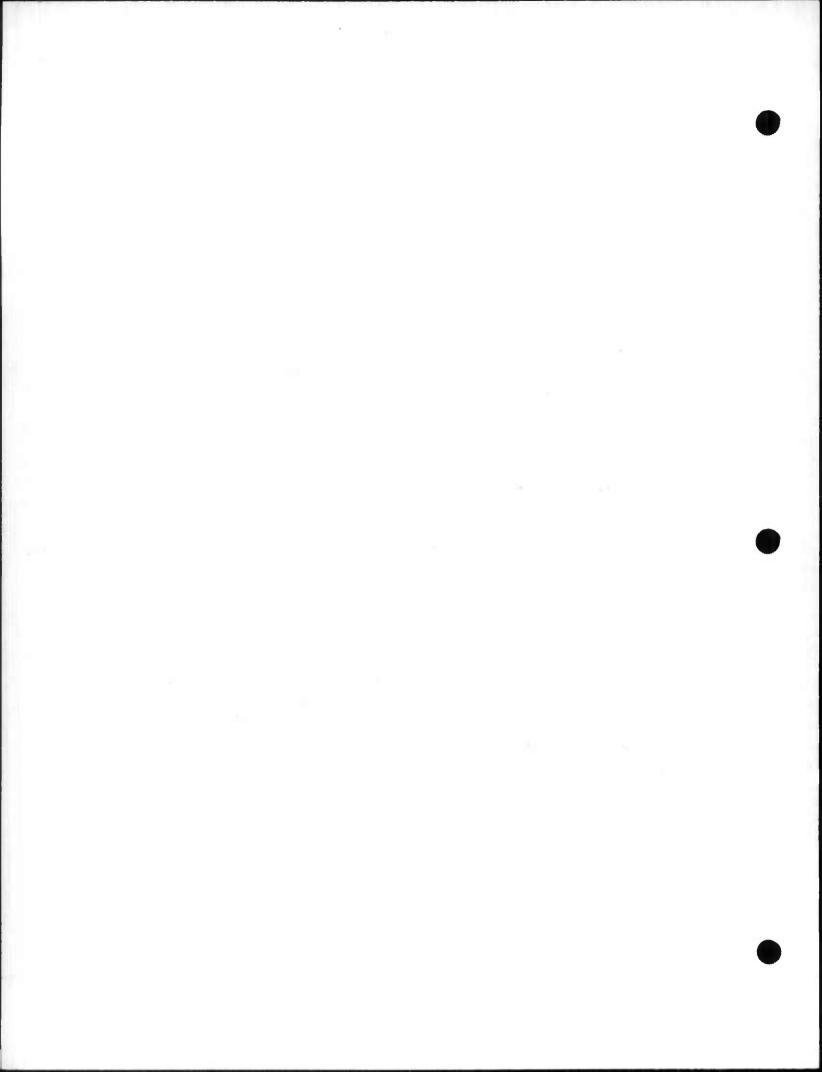


rospital or attending physician. Iched for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | l |
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| 98 | DIRE | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | te m | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARY | | MENT OF I | | MENTAL HYGIEI | | | | |
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| 10000 | DECEDENT'S NAME (First, Middle, Last) V | Villiam | | oper | | 2. DATE OF OEATH | | 3. TIME OF OEATH | | |
| 10 | | 5. SEX 6. AGE 1 ☑ M 2 ☐ F | (In yrs. lest birthday) 81 YRS. | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 07/28/1 | 10.5 | ORTHPLACE (State or Foreign Sountry) ryland | | |
| OR | 90. FACILITY NAME (If not institution, give street Memorial Hospit | | | | R LOCATION OF D | | 9c. COUNTY | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE Maryland Carc | oline | 10c. CITY, | TOWN OR LOCA | | ralsburg | | 10d. INSIDE CITY LIMITS? | | |
| 3AL D | 10s. STREET AND NUMBER | | | 10 | . ZIP CODE | 632 | | 1 XYES 2 NO OF WHAT COUNTRY? | | |
| FUNERAL | | 12. WAS DECEDENT EVER I | N U.S. ARMED | | ENDENT OF HISPAI | NIC ORIGIN? (Specify Ye | ne or No — 14. | ed States RACE — American Indian, Black, White, etc. | | |
| D 8Y | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) The specify of the kind of work done during most of working life. Do NOT use rational.) Acricult 11 TC | | | | | | | | | |
| PLETE | | | | | | | | | | |
| COMPL | Seventh 17. FATNER'S NAME (First, Middle, Last) | Windor B | Л НОС | ner | | ME (First, Middle, Meide | n Surname) | | | |
| TO BE | William Wesley Winder B. A. Hooper Carrie Smith 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Flural Flouris Flouris Flouris Flouris Street, Zip Code) Mary Audrey Hooper 801 Fair Haven Apts., Federalsburg | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Charlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cameling, cremetory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| | 23. PART I. Enter the disesses, or cor | | d the death. Do no | PO B | x 43, | Federals | burg, | MD 21632 | | |
| | shock, or heart fellure. Lie IMMEDIATE CAUSE (Final disease or condition | at only one ceuse on e | esch line. | | | | , and the same of | interval Between Onset and Death | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ALION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| CEHIIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF) | : | | | | | | |
| AL | PART II. Other significant conditions | contributing to deeth to | out not resulting in | the underlying | ceuse given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE | | |
| HYSICIAN: MEDIC | DID TOBACCO USE CONTRI | EKEBROVA | SCULAR | DISE | | 1 VES | 2,200 | OF DEATN? 1 YES 2 NO | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATN | | ONCERIAN | | | | | |
| L H | 27. MANNER OF GEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. INJ | | 8 Other (Specify) 28d. DE\$CRIBE HOW | INJURY OCCURE | 0 | | |
| 1 87 | 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | |
| COMPLEIED | 4 Homicide determined | building, etc. (Spe | | | | City or Town, State | | | | |
| 200 | (Check only one) 2 MEOICAL EXAMINER: | AN: To the best of my know On the beels of examination | | | | | | use(s) and manner se stated. | | |
| O DE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Spenn | | | 29c. LICENSE NUM | 16350 | 29d. DATE SIG | NED (Mogth, Day, Year) | | |
| | William S. Brem | er. M.D | 800 S. | | St., | St. Mich | aels, | MD 21663 | | |
| | 31. DATE FILEO (Month, Day, Yber) JUL 26 1995 | AEGISTHAR'S BIGH | at the solution | | · | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAR | | CERTIFIC | CALEO | FUEATH | A | REG. NO. | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF I | DEATH | | VE AD | 3. TIME OF DEATH |
| | WAYNE N | YERS E | HASTIN | GS | | AUG. | | , 19 | 95 | 10:30A M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yr | s. last birthday) | IF UNDER 1 YEAR | The second secon | 7. DATE OF E | BIRTH | | 8. BIRTH | IPLACE (State or Foreign |
| | 218-30-1268 13C M 2 C | F 5 | 59 YRS. " | ONTHS DAY | HOURS MIN. | (Month, De | 14/36 | 5 | Mar | yland |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | 9b. CITY, TOW | N OR LOCATION OF DI | | 1,00 | | ITY OF D | - ph |
| <u>د</u> | 306 Commerce Street | | | | Hurlock | | | Dor | aho | ster |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | HULLOCK | | | DOI | CHE | Ster |
| E I | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Dorcheste | er | | | Hur1 | ock | | | | 1 X YES 2 NO |
| AL | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | 10g. CITI | ZEN OF W | VHAT COUNTRY? |
| EB | 306 Commerce Stree | t | | | 2164 | 13 | | Uni | ted | States |
| FUNERAL | | DENT EVER IN U.S | | 13. WAS D | ECENDENT OF HISPAI | NIC ORIGIN? (S | pecify Yea o | or No- | 14. RACE | - American Indian, |
| | IF YES GIV | 1 X YES 2 E WAR OR DATES | | | specify Cuban, Mexica ES 2 X NO Specif | | n, etc.) | | | t, White, atc. |
| BY | 3 Widowed 4 Divorced | 4-1958 | | 1 | as a gg tro | , | | | Ореси | [™] White |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 164 | Give kind of wo | SUAL OCCUPA | TION | 16b. KIN | ID OF BUSI | NESS/IND | USTRY | |
| 画 | Elementary/Secondary (0-12) College (1-4 or | | life. Do NOT use | retired.) | most or working | 0.00 | . 4. 4 | | 1 0 | |
| ᅙ | 9th-G.E.D. |]] | Inspec | tor | | COL | ICINE | enta | II C | an Co. |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middl | le, Maiden Si | urneme) | | |
| BE | Chester | M. Has | stings | | Nina E | Belle | Dunr | 1 | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street | et and Number or Rural | Route Number, C | City or Town, | State, Zip | Code) | |
| 일 | Mary Hastings | | P.O.1 | 30x 1 | 95, Hurl | lock, | MD 2 | 2164 | 3 | |
| | 20e. METHOD OF DISPOSITION | 20b. PL | ACE AND DATE OF | DISPOSITION | Name of | DATE | 20c. LOCA | | | wn, Stata |
| | 1XC Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) | MC P | Kendre | er place) e Cem | eterv | 15 | Rho | odes | da1 | e, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME | AND ADDRESS OF FA | CILITY | | | | |
| | muland 7-8. Por | 14- | | | | | | | | eral Home |
| \dashv | The state of the s | PV . | | PO | Box 43, | Feder | alsl | ourg | , M | D 21632 |
| | 23. PART I. Entar tha diseases, or complications shock, or heart fallure. List only one | that caused the | s dasth. Do no iina. | t antar tha r | node of dying, suc | h as cardiac | or respire | itory arre | est, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final | 00.0 | | | | | | | | Onset and Death |
| - 1 | disease or condition Cachos | | | | | | | | | |
| ļ | resulting in death) a Cacriexta | | | | | | | | | |
| | DUE | TO (OR AS A CO | esemble | - | | | - | | | |
| NC | Due Carcin | to (or as a con nomatosi | s | | | | | | | |
| ATION | Sequantially list conditions, If any, laading to immediate | TO (OR AS A COI DOMATOSI TO (OR AS A COI | S NSEQUENCE OF): | · · · · · · · · · · · · · · · · · · · | | | | | | |
| ICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | TO (OR AS A COI | s nsequence of: na of Si | gmoid | | | | | | |
| TIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | TO (OR AS A COI DOMATOSI TO (OR AS A COI | s nsequence of: na of Si | gmoid | | | | | | |
| SERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | TO (OR AS A COI | s nsequence of: na of Si | gmoid | | | | | | |
| L CERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | TO (OR AS A CO) COMMENTO SI TO (OR AS A CO) CATCINON TO (OR AS A CO) | S NSEQUENCE OF): 1A Of Si NSEQUENCE OF): | gmoid | ing cause given in | Part I. 24a | I. WAS AN AI | UTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | TO (OR AS A CO) COMMENTO SI TO (OR AS A CO) CATCINON TO (OR AS A CO) | S NSEQUENCE OF): 1A Of Si NSEQUENCE OF): | gmoid | ing cause given in | | PERFORM | ED? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDICAL | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | TO (OR AS A CO) COMMENTO SI TO (OR AS A CO) CATCINON TO (OR AS A CO) | S NSEQUENCE OF): 1A Of Si NSEQUENCE OF): | gmoid | ing cause given in | | | ED? | 24b. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| uires that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or attending physician. | signed by the attending physician and complete | Health and Mental Hygiene pr |
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

it permit. Pages 1, 2, 3 should TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow reference of any be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DONALD G. WRIGHT

31. DATE FILED (MONTH), DOY, 106 1995 37

| FOR | CTATE OF MADVI | AND / DEPARTS | JENT OF HE | ITH AND I | MENTAL HVOLEN | | 3 21055 | | | |
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| 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | STATE OF MARYL | | ATE OF D | | REG. NO. | <u> </u> | 3. TIME OF DEATH | | | |
| JOHN RAY | HUTCH | TSON | | | AUG. 12 | 199 | YEAR | | | |
| 4. SOCIAL SECURITY NUMBER 217-36-0198 | | (In yrs. last birthday) | F UNDER 1 YEAR II | 7. DATE OF BIRTH (Month, Day, Year) JUNE 5, 1 | T a | 5 10 · 43 A BIRTHPLACE (State or Foreign Country) MARYLAND | | | | |
| | | | | | | | | | | |
| 9e. FACILITY NAME (If not institution, give 131 BARTON RO RESIDENCE OF DECEDENT | | • | OUEEN | | | | EN ANNE 'S | | | |
| 10a. STATE 10b. COUNT | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | |
| 100. STREET AND NUMBER 131 BARTON RO | AD | | 10f, Zi | 21657 | 7 | | N OF WHAT COUNTRY? | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2X NO | 13. WAS DECENI If yes, specif 1 VES 2 | DENT OF HISPAN Cuben, Mexica NO Specify | NIC ORIGIN? (Specify Yes in, Puerto Rican, atc.) | or No— 14 | 4. RACE — American Indian, Black, White, atc. Specify: WHITE | | | |
| 15. DECEDENT'S EDI (Specify only highest grad Elementery/Secondery (0-12) 11 17. FATHER'S NAME (First, Middle, Last) | UCATION (e completed) College (1-4 or 6+) | ille. Do NOT use r | k done during most o etired.) | f working | 16b. KIND OF BUS | | | | | |
| 11 | | FARM | MER | | AGR | ICUL | FURE | | | |
| MARTIN | HUTCHISON | | 1 | | ME (First, Middle, Melden JRA GE | | | | | |
| ANNA MAE HUTC: | HISON | | | | Route Number, City or Town | | | | | |
| 20e, METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rer 4 Donation 6 Other (Specify) | | FATRVIEW | | | | | ty or Town, State A, MD 21625 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE L | the Physic | w, CFS7 | NEWNA | | ERAL HOME | | | | | |
| 23. PART I. Enter the diseases, or ahock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Arterios | each line. | | | disease | ratory erre | at, Approximeta Interval Betwe Onset end Da | | | |
| Sequentielly list conditions, if erry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS a | A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other algorificant condition Arterioscleristic | | 4 4 | | ause givan in | Part I. 24a, WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION DF CAUS. OF DEATH? 1 XYES 2 NO | | | |
| DID TOBACCO USE CON | TRIBUTE TO CAUSE O | | | UNCERTAI | N X | | X | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH | (Check only one) | | | | | | | |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 8 Pending | 1 Inpatient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Yeer) | | OF 28c. INJUR | Y AT | 6 Other (Specify) 28d. DESCRIBE HOW I | NJURY OCCU | IRED | | | |
| 2 Accident 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | 28s. PLACE OF INJUR | IY — At home, farm, streecify) | | 3 2 NO | 281. LOCATION (Street City or Town, State) | | r Rural Route Number, | | | |
| 29a. CERTIFIER (Check only one) | 29a. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 2 X MEDICAL EXAMIN | | on una/or investigation, | | | | | cause(s) and manner as stated | | | |
| 206. SIGNATURE AND TITLE OF CERTIFIC | 7. Wright 1 | ND | | 9c. LICENSE NU | MBER F | • | SIGNED (Month, Day, Year) CUST 13 190 | | | |
| | IGHT MD | 111 P | | ceet, | Baltimore | , Ma | ryland 2120 | | | |
| 31. DATE FILED (Month, Day, Your 19 | 95 32 heastrains sig | | | | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TILTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an ompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

| | 1 - STATE REGISTRAR | CE | RTIF | ICATE O | F DEATH | | BE | G. NO |) | | | |
|---------------|-------------------------------------------------------------------------------------------------|----------------------------------|----------------|----------------------------------|-----------------------------------|-----------|--------------------------|----------|--------------|-------------|--------------------------------------|-------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2.1 | DATE OF DE | EATN | | | 3. TIME OF DEAT | N |
| | Annie Virginia I | <i>l</i> einzmanr | 1 | | | | юнтн Augus | | 12, I | YEAR 995 | 4:55 | Рм |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER 1 YEA | R IF UNDER 24 HR | RS. 7. C | ATE OF BI | RTN | 1 200 1 | | PLACE (State or For | - |
| | 579-24-1396 1 M 2 XXF | 81 | YRS. | MONTHS DAY | HOURS MIT | | Month, Day. | | 101/ | Counti | Market, | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | 9b, CITY, TOW | N OR LOCATION O | | 11. 1. | + , | | INTY OF D | | VA |
| œ. | South River Nursing Center Edgewater Anne Aru | | | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | Lagewe | | | | | AIII | ie Al | under | |
| E I | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | | 10d. INSIDE CITY | |
| | Maryland Anne Arunde | 1 | Lo | thian | | | | | | | tX YES 2 □ | NO |
| A | 10. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CI | TIZEN OF V | WHAT COUNTRY? | |
| 5 | 227 Wayson's Court | | | ŀ | 20711 | | | | t | Inite | d States | |
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| | | | | | | | | | | Wh | ite | |
| 国 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (G | ive kind of s | USUAL OCCUPI work done during | | | 16b. KIND | OF BU | SINESS/IN | DUSTRY | | |
| اي | Elementary/Secondary (0-12) College (1-4 or 5 | +) | Do NOT us | Clerk | | | Pote | 11 | Sale | . 5 | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | ales | CIEIK | 1 | | | _ | | | | |
| | | | | | 18. MOTNER'S | | | | Sumame) | | | |
| B | Henry Good 19a, INFORMANT'S NAME (Type/Print) | | | | | | alyan | | | | | |
| 2 | Joseph Heinzmann | 194 | | | s Ct. | | | | vn, State, Z | | | |
| | 20s. METNOD OF DISPOSITION | 1 | | OF DISPOSITION | | - | | | | | | |
| | 1 XBurial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) | cemetery, cre | metory or o | ther place) | | 1 | /14 | | | City or To | wn, State Virgini | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Emmar | ueı | Cemete: | AND ADDRESS OF | _ | | Me | w Mai | ket, | VIIgIIII | .d |
| | 181 0 | | | | AND ADDITEGO OF | TAULI | The: | Ĺs : | Funer | cal C | hapel | |
| | Steven 7.1 | Moto | del | P.0 | Box 41 | 9 N | ew Ma | ark | et, \ | /irgi | nia 2284 | 4 |
| | 23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one can | at coused the de | eth. Do r | not enter the | mode of dying, | such as | cardiac o | r reap | Iratory a | rrea1, | Approxima | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | |
| | disease or condition resulting in death) a. Algheimed Dielecte On AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | O)E TI | OR AS A CONSE | DUENCE O | F): | | | | | | | | |
| Z | Sequentially list conditions. | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediata cause. Enter UNDERLYING | | | | | | | | | | | |
| 일 | CAUSE (Disease or Injury C. | DUE TO (OR AS A CONSEQUENCE OF); | | | | | | | | - | | |
| Ē | that initiated events resulting in death) LAST | ON AS A CONSEC | NSEQUENCE OF): | | | | | | | | j | |
| B | d | | | | | | | | | | - | |
| | PART II. Other significant conditions contributing to | daath but not r | eaulting | in the undarly | ing cause given | n In Part | l. 24a. | | AUTOPSY | 24b | WERE AUTOPSY FIR | |
| DICAL | | | | | | | | | RMED? | | COMPLETION DF C | AUSE |
| Ĭ | | | | | | | | | 1 | | OF DEATH? | 0 |
| ž | | | | | | | | | | | | |
| Y. | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26 | PLACE OF DEATN | Check or | nly one) | | | | | |
| is | HOSPITAL: | ☐ ER/Outpatient 3 | □ DOA | OTHER: | ome 5 🗆 Residen | nca 8 🗆 | Other (Spec | ify) | | | | |
| PHYSICIAN: ME | 27. MANNER OF DEATN 28s. DATE O | F INJURY Day, Year) | 28b. TIM | - | NJURY AT WORK? | _ | DESCRIBE | | INJURY O | CURED | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | "" | | YES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be 28e. PLACE building | OF INJURY - At ho | me, farm, : | street, factory, o | fica | 261. | LOCATION City or Town | (Street | and Numbe | or Aural F | Route Number, | |
| COMPLETED | 4 Nomicide determined | , | | | | | City or row | i, Siele | , | | | |
| ן ב | 29a. CERTIFIER (Check only 1 DERTIFYING PHYSICIAN: To the best of | if my knowledge, de | sth occum | ed at the time, d | eta and placa, end | due to th | o Causa(a) : | and me | nner as str | rted. | | |
| ₹ | one) 2 MEDICAL EXAMINER: On the basis of | | | | | | | | | | end manner as st | nted. |
| | 29b. CERTIFIER | | | | 29c. LICENSE | | | | | | | |
| BE | 1AM 7 | \ | | | D389 | | | | 290. DA | 11. | (Month, Day, Year) | |
| 임 | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAL | JSE OF DEATH (ITF | W 27) (Turne | Print) | 10009 | 100 | | | | 114 | 14> | |
| | DALTERT SINGH SIDI | | | | D4 03- | | N/E | 1111 | 7 | | | |
| | 31. DATE FILED (Month, Day, Year) 24REGIST | ARS SIGNATURE | AUI | auulls | Rd Ode | ILLOI | | ull | 2' | | | _ |
| - 81 | AUG 22 1995 July 201 | morton story | 4.24 | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

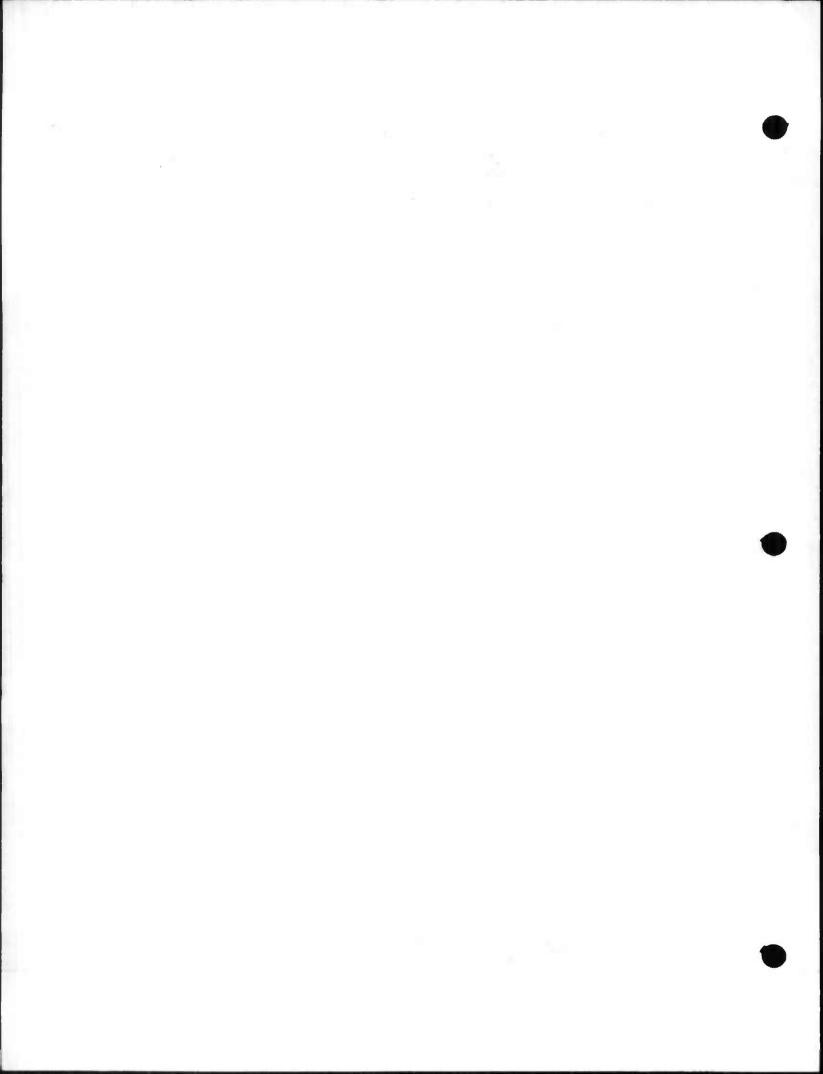
IMPORTANT: If them 28 is marked, or tiem 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

AUG

3

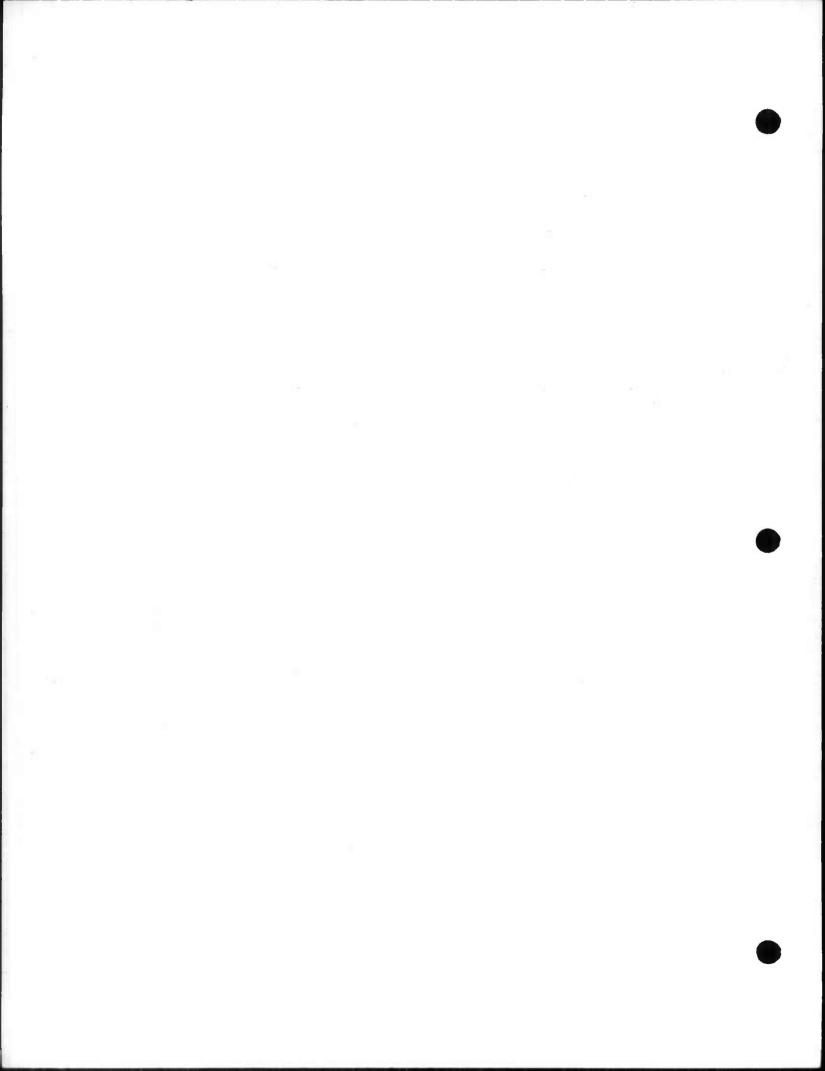
| | | | | | | C | 5 27095 |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------|-------------------------------------------------------------------|---------------------------------------------|-------------|--------------------------------------------------------------------|
| | Amended # 2 , 8/30/95 LH . FOR STATE OF MARY! | Fred. Co | | | | | |
| | 1 - STATE OF MARY! | LAND / DEPARTM | MENT OF H | EALTH AND MEI | NTAL HYGIENE | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | 4 | | 2. | REG. NO. | 0 24 | 1005 3. TIME OF DEATH |
| 1 | | ICKMA | | | S 2 | 7-19 | 95 12 49 " |
| 1 | 578-05-2954 1 D M 2 🔀 9 | 2 YRS. MO | UNDER 1 YEAR | HOURS MIN. | | | Maryland |
| H | 9a. FACILITY NAME (If not inetitution, give street and number) | | | OF DEATH gomery | | | |
| DIRECTOR | ROCKUILLE NURSING RESIDENCE OF DECEDENT 100. STATE 100. COUNTY | | DWN OR LOCAT | ville | | MOTIL | |
| DIRI | Maryland Montgomery | 77.7 | ckvill | | | | 10d. INSIDE CITY LIMITS? 1X YES 2 NO |
| 3AL | 10e. STREET AND NUMBER | | 101 | ZIP CODE | | | EN OF WHAT COUNTRY? |
| FUNERAL | 303 Adclare Road 11. MARITAL STATUS 12. WAS DECEDENT EVER | W. I. S. A. DALED | 1 | 20850 | | U.S | |
| BY FU | 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Never Married 2 IF YES, GIVE WAR OR I | 2 NO | If yes, sp | ENDENT OF HISPANIC O lefty Cuben, Mexican, Pi 2 NO Specify: | | or No 1 | 4. RACE — American Indian, Black, White, etc. Specify: White |
| ED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USI | | | 18b. KIND OF BUSI | NESS/INDU | STRY |
| COMPLET | Elementary/Secondary (0-12) College (1-4 or 5+) | Office M | tired.) | a warang | Dairy (| Compa | ny |
| CO | 17. FATHER'S NAME (First, Middle, Lest) | | | 18. MOTHER'S NAME (| | | _ |
| BE | Charles D. Hic | | | Annie | | Micha | |
| 2 | Mr. John C. Hickman | | | ms Street, | | | |
| | 20e. METHOD OF DISPOSITION 20 1 1 Burlal 2 Cremation 3 Removal from State | b. PLACE AND DATE OF D | DISPOSITION (Na | me of | DATE 20c. LOC | ATION — CI | ty or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | ount Olivei | 22. NAME AN | D ADDRESS OF FACILIT | TY | | ck, Maryland |
| | ► A00 au 9/ 10,00 | M00703 | | y & Basfor | | | |
| | 23. PART I. Enter the diseases, or complications that cause | ed the death. Do not | enter the mo | ast Church de of dying, such as | St., Fre | atory arres | ck, MD 21701 |
| | shock, or heart failure. List only one shuse on immediate CAUSE (Final | nach line. | | | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | 4+ | | | | | Out hour |
| _ | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate | A CONSEQUENCE OF): | | | | | |
| CA | CAUSE (Disease or Injury | A CONSEQUENCE OF): | | | | | |
| E | that initiated events resulting in death) LAST | A CONSEQUENCE OF): | | | | | |
| 8 | DADT II Other significant conditions contain the death | - A A | | | | | |
| EDICAL | PART II. Other significant conditions contributing to death | out not resulting in t | ne underlying | cause given in Pan | PERFORM | NED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE |
| MED | HYDOTHYRUIA | 1 40 | | | 1 TYES 2 | NO. | OF DEATH? 1 □ YES 2 NO |
| | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | σ | 26. PL THER: | ACE OF DEATH (Check o | only one) | | |
| 14S | 1 YES 2 NO 1 Inpetient 2 ER/Out | | Nursing Hom | 5 Residence 6 | Other (Specify) 1. DESCRIBE HOW IN | HIEW OCCU | INFO. |
| ВУ Р | 1 Natural 5 Pending (Month, Day, Year) | INJURY | WO | PK7 ES 2 NO | . DESCRIBE HOW IN | JUNY OCCU | HED |
| 8 | - Control - Cont | Y — At home, ferm, stree | et, factory, office | 269 | LOCATION (Street ar City or Town, State) | d Number of | r Flural Route Number, |
| | 29a. CERTIFIER | wlados dost | d the time and | | | 242 | |
| COMPLET | (Check only one) Check only one) CERTIFYING PHYSICIAN: To the best of my known one) MEDICAL EXAMINER: On the basis of examination | | | | | | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c, LICENSE NUMBER | | | BIGNED (Month, Day, Year) |
| 00 | Courte cost mo | | | 03183 | 9 | PA. | 22+27199 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, Pre | nr) | 615 h | rut in | 041 | 50 min A. |

32 REGISTRANT SIGNATURE RANGES



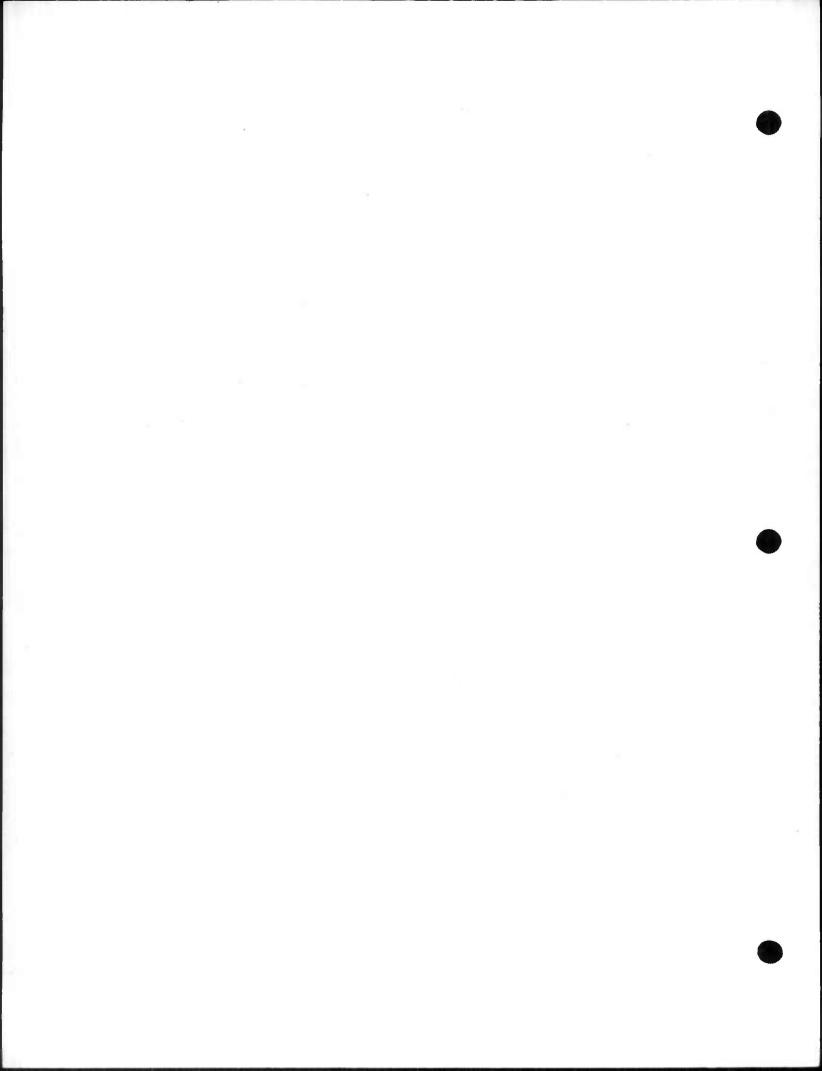
| BALT | fler death. |
|-------------------------------------------|-------------------------------------------------------------------------------------|
| _ | hours a |
| | 77. U |
| 60 | with |
| 687 | ecuted |
| × | 96 BK |
| O. BC | he law requires that the death certificate be executed within 24 hours after death, |
| S, G | death c |
| Ö | the |
| H | that |
| REC | requires |
| _ | WE |
| A | E E |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | IE HOSPITAL OR ATTENDING PHYSICIAN: The |
| S | DING |
| 2 | ATTEN |
| 5 | 8 |
| _ | HOSPITAL |
| | ш |

| | | FOR STATE REGISTRAR | STATE OF MARY | | RTMENT OF I | | | HYGIENE REG. NO. | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------|--------------------------------------------------|----|
| | | 1. DECEOENT'S NAME (First, Middle, Last | 0 | | | | 2. DATE OF | DEATH | 3. TIME OF DEATH | |
| | 1 | HERBERT SPENCE | R HOWELL | | | | AUGUS | | 5 1635 | М |
| | | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF (Month, Da | BIRTH (| B. BIRTHPLACE (State or Foreign Country) | |
| should | | 578-46-7657. 9e. FACILITY NAME (N not institution, give | 1 M 2 F 80 | YRS. | | | Jan,24 | | ashington,D.(| 3. |
| 2, 3 sho | стов | Washington Adv | , | :al_ | | or Location of d na Park | EATH | | gomery | |
| les 1 | i iii | RESIDENCE OF DECEDENT 10e. STATE 10b. COUN | ITY | 10c. CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY | = |
| t. Pages | DIR | Maryland Mon | tgomery | S | ilver Sp | oring | | | LIMITS? | |
| permit. | AL | 10e. STREET AND NUMBER | | | | r. ZIP CODE | | 10g. CITIZE | EN OF WHAT COUNTRY? | _ |
| 020 physician. burlal-transit | NER | 204 Whitestone | | | | 2090 |)1 | U | .S.A. | |
| 20 Mysicii urial-t | ED BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 PNO | | CENDENT OF HISPA | | | 4. RACE — American Indian, Black, White, etc. | |
| 5-0020 nding physic is the burial | | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | | 3 2 NO Specif | | , | Specify: | |
| attending use as the | | 15. DECEDENT'S ED (Specify only highest grad | | 16e. DECEDENT'S | USUAL OCCUPATI | ON | 16b. KII | ND OF BUSINESS/INQU | White stay | _ |
| 12 S | LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | work done during mo se retired.) | ost of working | | | | |
| AND 21: the hospital or detached for u | COMPL | | 3 | Owner Op | erator | | | Order Bu | siness | |
| Z 2 2 5 | - 1 | 17. FATHER'S NAME (First, Middle, Last) | 1.1 | | | Activities of the control of the con | 15,15 | le, Malden Surname) | | |
| | BE | Herbert How | well | 195 MAILING | ADDRESS /Street | | | Spencer City or Town, State, Zip C | | _ |
| 5 5 5 | 임 | Dorothy S. How | e11 | | hitestor | | | | aryland 2090] | 1 |
| may be | | 20a. METHOD OF DISPOSITION | 20c LOCATION CI | ty or Town State | | | | | | |
|) w & 2 | | 1 Buriel 2 Cremation 3 Red 4 Donalion 5 Other (Specify) | Movel from State | metery, crematory or o letropoli | tan Cren | natory 8/ | /22/95 | Alexandri | a,Virginia | |
| ALTIN death. Pag tuneral di i. | | 21. SIGNATURE OF FUNERAL SERVICE L | JCENSEE | | 22. NAME A | ND ADDRESS OF FA | CILITY | uneral Ho | | |
| BAL the fun wal. | | Jeven) | Strond | | 1 | | | | pr.,MD 20901 | |
| bAL I IM hours after death. Page ed in by the funeral direct or removal. medical examiner in | | 23. PART I. Enter the diseases, or shock, or heart failure | complications that cause b. List only one cause on | d the desth. Do r | not anter the mo | oda of dying, suc | h ss cerdiac | or respiratory street | st, Approximats | |
| 74 hour filled ition, or the m | | IMMEDIATE CAUSE (Final | | oddii iii70. | | | | | Interval Betwee | |
| od within 24 ompletely fille it, cremation, event, the | | disease or condition resulting in death) | s. Pneumonia | | | | | | 2 months | 3 |
| A 2 2 - 9 | _ | | | A CONSEQUENCE O | F): | | | | 10 | |
| 8 0 6 | ő | Sequentially list conditions, if any, lasding to immediate | oue to (or as | A CONSEQUENCE OF | F): | | | 10 years | 3 | |
| 2 6 G 6 | S | CAUSE (Disease or injury | | | | | | | | |
| n certificate nding physical profiles p | RTIFICATION | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | |
| 7 = 8 - 0 | CER | | d | | | | | | | |
| | I II | PART II. Other significant condition | | but not reaulting | in tha undarlyin | g cause given in | Part i. 24 | . WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO | GS |
| 3 2 5 C | MEDICAL | Atrial Fibrilla | tion | | | | 1 | YES 2 TO NO | COMPLETION OF CAUSE OF DEATH? | 1 |
| law requires the as been signed bept, of Health a 23 shows any | | Aortic abdomina | | | | | | | 1 TES 2 NO | |
| law bept. | AN: | DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL | TRIBUTE TO CAUSE C | 26. PLACE OF DEAT | | UNCERTAI | ИП | | | _ |
| - 두 음음 등 | SICIA | EXAMINER? | HOSPITAL: | | OTHER: | | | 20.7 | | _ |
| PHYSICIAN: this certifica with the St rked, or it | РНҮ | 27. MANNER OF OEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c, INJ | URY AT | | BE HOW INJURY OCCU | RED | _ |
| | ВУ | 1 Natural 5 Pending 2 Accident Investigation | | - INJ | | YES 2 NO | | | | |
| J 5 4 5 | 0 | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, atc. (Spe | Y — At home, farm, a | street, factory, offic | • | 281, LOCATIO City or To | N (Street end Number or wn, Stete) | Rural Route Number, | |
| OR ATTENE DIRECTOR: hours after item 28 is | ETE | | | | | | | | | |
| 422 | MPL | | SICIAN: To the best of my know | | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL DE fled within 72 t IMPORTANT: If | 8 | | NER: On the beele of examination | on end/or investigatio | n, in my opinion, d | | | place, and due to the | rause(s) end manner es stated. | |
| 를 를 를 | H | 29b. SIGNATURE AND TITLE OF CERTIFIE | 01 70 | 190 | | 29c. LICENSE NUI | | 29d. DATE 5 | BIGNEO (Month, Day, Year) | |
| ₽ ₽ ≥ ₹ | 2 | 30. NAME AND ADDRESS OF PURSON W | HO COMPLETEO CAUSE OF DE | EATH (ITEM 27) (Type | Print) | 1+3511 | 6 | 8 | 120175 | |
| 10 | | Nicholas J. Plac | | | | Drive Si | lver S | hrino Mar | vland 20901 | |
| 10 | | 31. DATE FILED (Month, Day, Year) AUG 24 1995 | July Dander Ro | MATURE ! | | D1 | 2.01 | Prins, Hal | , 14114 20701 | |
| | | HUU 64 1995 | July marge an | - A-1-1 | | | | | | |



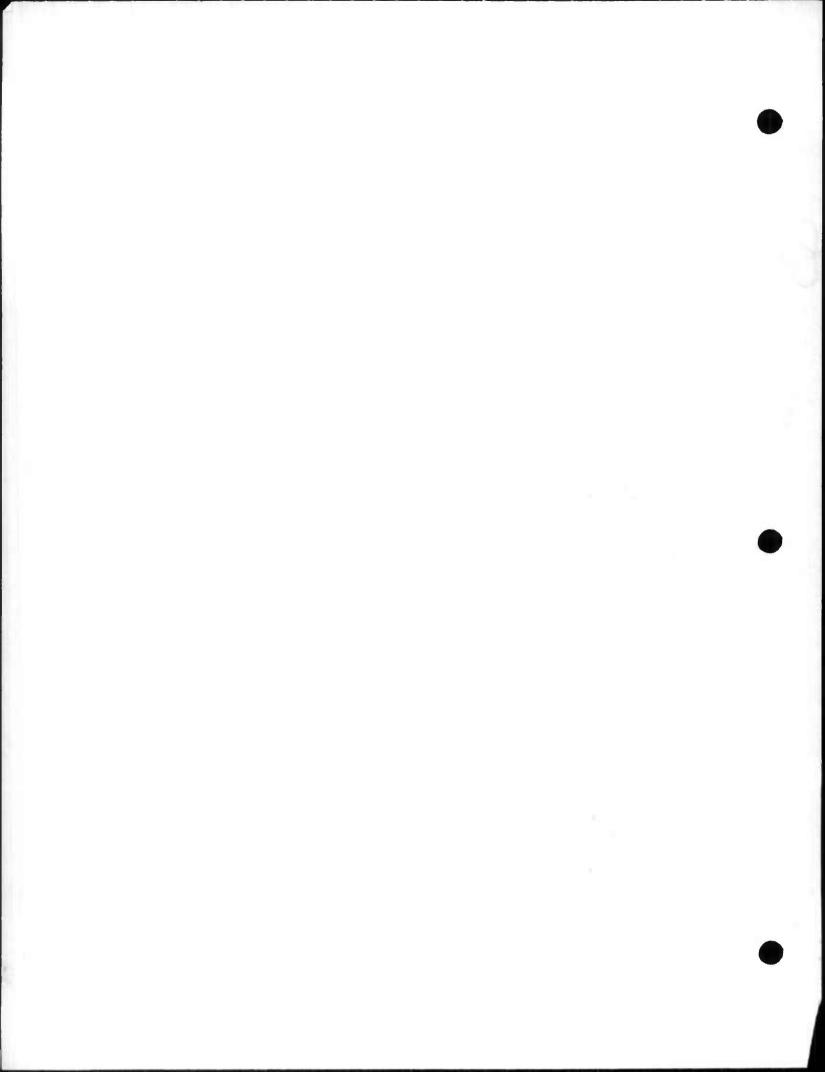
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | | | | |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------|-----------------------|--------------------------------|-------------------------------------------------|---------------------|--------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | ALEMAYEHU | HAILMAR | RIAM | | | August 12 | , 1995 | 7:14 A | | |
| | 4. SOCIAL SECURITY NUMBER | | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT | HPLACE (State or Foreign (nv) | | |
| | 579-04-2875 | 1 X XM 2 □ F 4 | | Aug 22, 1950 Ethiopia | | | | | | |
| œ | 9a. FACILITY NAME (If not institution, give st | • | | | R LOCATION OF DE | EATH | 9c. COUNTY OF | DEATH | | |
| DIRECTOR | Washington Adven | tist Hospita | I : | Cakoma | Park | | Montgor | nery | | |
| H | 10a. STATE 10b. COUNTY | | 18c. CITY, TO | OWN OR LOCATI | ON | | | 10d. INSIDE CITY | | |
| | | e George | Tako | ma Par | k | | | 1XXYES 2 NO | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 1 | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | |
| NE | 6733 New Hampshi | re Avenue, A | | | 20912 | | | States | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes, spe | olfy Cuban, Maxican | IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | Blac | E — American Indian, ik, White, etc. | | |
| 84 | 3 Widowed 4 X Divorced | IF TES, GIVE WAR ON D | ALES | 1 🗆 YES | 2 👸 NO Specify | 7 | Spe | Black | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DECEDENT'S USI | | | 16b. KIND OF BU | SINESS/INDUSTRY | Didek | | |
| LE | Elementary/Secondary (0-12) | College (1-4 or 5+) | IIIe. Do NOT use re | tired.) | | | | | | |
| OMP | 12 | 4 | Property | Manage: | | | ng Indust | ry | | |
| | Haile Mariam Abe | 0.0.7 | | | | ME (First, Middle, Melden | Surname) | 13 | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | gaz | 19b. MAILING AD | DRESS (Street an | Chaltu | J1mma Route Number, City or Tow | on State 7in Code | | | |
| 2 | Tekleab Alemayeh | u | 1 | | | | | 20912 na Park, MD | | |
| | 20s METHOD OF DISPOSITION 12 Duriel 2 Cremetion 3 Remo | 20b | PLACE AND DATE OF D | ISPOSITION (Nan | | | CATION — City or T | | | |
| | 4 Donation 5 Other (Specify) | G | etery, crematory or other ate of Hea | ven | | 8/16 Sil | ver Spri | ng, Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENGEE | / | | ADDRESS OF FAC | эштү Funeral Ho | | | | |
| - / | Judien 5. | Justh | | | | | | Spring, MD | | |
| 0 | 28. PART I. Enter the diseases, or c | omplications that caused list only one cause on a | the deeth. Do not | enter the mod | e of dying, auch | a cerdiac or reapi | refory arrest, | Approximate | | |
| | IMMEDIATE CALIDE (Elect | Cardio | - Resp | | _ | | D . | Interval Batween Onset and Death | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| AL C | PART ii. Other algolficant condition | contributing to death b | ut not resuiting in ti | ne underlying | ceuse given in i | | | . WERE AUTOPSY FINDINGS | | |
| 20 | | | | | | PERFOR | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| PHYSICIAN: MEDIC | | | | | | | | 1 YES 2 NO | | |
| ÿ | DID TOBACCO USE CONTR | | | | UNCERTAIN | 1 🗆 | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (C | HER: | | | | | | |
| ₹S | 1 YES 2 NO | 26a. DATE OF/INJURY | atlant 3 DOA 4 DOA 4 D | | | 6 Other (Specify) | | | | |
| ВУ Р | 1 Naturel 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | WOR | | 28d. DESCRIBE HOW II | NJURY OCCURED | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, term, stree | t, factory, office | | 281. LOCATION (Street a City or Town, State) | and Number or Rural | Route Number, | | |
| COMPLETED | | CIAN: To the beat of my knowl | | | | | | s) and manner as stated, | | |
| BE C | 296 SIGNATURE AND TITLE OF CERTIFIER | dr | | | 29c. LICENSE NUM | BER | 29d. DATE SIGNED | (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH /ITEM 27 /Ton Date | el. | DAIL | d | 00 | 7645 | | |
| | Try (TAT | out IT- | 100 Mi | | nlle Rd | Bell | c'mp | 20716 | | |
| | 31. DATE FILED (Month, Day, Year) AUG 21 1995 | 32. REGISTRAR'S SIGN. | Carefall | | | | | | | |
| | | / | | | | | | | | |



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF DEA | | | 1: | 3. TIME OF DEATN |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------|-----------------------------------------|--------------------|-------------|------------|--------------|----------------------------------------|-----------|-----------|------------|-----------------------------------|
| | William | | Newton | | Н | Hurley | | | | August 20,1995 6:30 P. | | | | 6:30 P. M |
| | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 6. AGE (In yrs. | | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7 DATE OF BIE | TH | | S. BIRTHPI | LACE (State or Foreign |
| | 042-09-4550 | | 1 🔀 M 2 🗌 F | 84 | VRS. MONTHS DAYS HOURS MM. Sept. 21, 19 | | | | 910 Kentucky | | | | | |
| ~ | 9a. FACILITY NAME (If not in | | | | | | | OR LOCATI | _ | ATN | 9 | c. COUN | TY OF DE | ATN |
| DIRECTOR | Potomac Va | lley N | ursing H | lome | | Rockville Montgome | | | | | gome | ry | | |
| <u>a</u> | 10a. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCA | ION | | | | | 1 | IOd. INSIDE CITY |
| | none | none | 2 | | Was | hing | ton, | D.C | | | | | 1 | LIMITS? YES 2 NO |
| Z | 10e. STREET AND NUMBER | | | | | | 10 | ZIP COD | E | | 10 | 0g. CITIZ | EN OF WH | IAT COUNTRY? |
| FUNERAL | 1435 N St. | ,N.W. | #206 | | | | | 20 | 005 | | | U | J.S.A | • |
| 급 | 11. MARITAL STATUS 1 X Never Married 2 | Married | | YES 2 X | NO NO | 13. | If yes, sp | ecify Cuba | n, Maxica | HC ORIGIN? (Spec n, Puerto Rican, e | | No- | | – American Indian, White, etc. |
| 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: White | | | | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | | | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | | | | | | | | | | | |
| MP | 17 FATHED'S NAME (First A | lickella (aat) | 4 | S | ecuri | ty g | uarc | | | | | | rnme | nt |
| | | | | | | | | | | | | | | |
| BE (| 19a. INFORMANT'S NAME (| | | | 19b. MAILING | ADDRES | S (Street a | nd Number | | | | | Corde) | |
| 2 | 19a. INFORMANT'S NAME (Types/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 N. St., N.W., #102, Wash., D.C. 20005 | | | | | | | | | | | | | |
| | 20a. METNOD OF DISPOSITION 1 XBurlai 2 Cremation 3 Removal from Stata 4 Donation 6 Other (Specify) Mt. Olivet Cemetery Aug. 22,95 Washington, | | | | | | | | | n, Stata | | | | |
| | 4 Donation 6 Other | (Specify) | | Mt. | <u>Olive</u> | t Ce | mete | ry | Aug | .22,95 | Wa | shin | gton | , D.C. |
| | 21. SIGNATURE OF TUNERA | L SERVICE LIC | ENSEE /// | / | | 22. | NAME A | ID ADDRES | SS OF FAC | Home | | | | |
| _ | ames | 129 | 101 | | | 2 | 222 | Wisc | onsi | n AVe. | N.W. | ,Was | sh.,D | C 20007 |
| | 23. PART L Enter the d ahock, or h | iseases, or c eert fallure. I | omplications the list only one cau | t caused the dise on each life | death. Do i ne. | not enter | the mo | de of dyl | ng, such | n aa cerdiac or | reapirate | ory arre | st, | Approximate interval Between |
| | IMMEDIATE CAUSE (Fir disease or condition | iei | | | | - | | | | | | | | Onset and Death |
| | resulting in daeth) | → , | | yocardi | | | tion | | | | | | | immediate |
| 2 | | | 552.10 | (on no n conc | EGOTNOE O | | | | | | | | | |
| CERTIFICATION | Sequantially list conditi if any, leading to imme | diete | DUE TO | (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| <u>Ş</u> | cause. Enter UNDERLY | | OUE TO | 100 45 4 00 VO | | _ | | | | | | | | |
| | that initiated events resulting in desth) LAS | T | DOE 10 | (OR AS A CONS | EUVENCE U | F): | | | | | | | | |
| 8 | | | | | | | | | | | _ | | | |
| MEDICAL | PART II. Other algnifice | | | deeth but not | resulting | in the ur | nderlying | ceuse g | jiven in l | Part i. 24a. W | AS AN AUT | | | PERE AUTOPSY FINDINGS |
| ă | OIGANIC | JI dilli s | Syllarome | | | | | | | 1 U Y | ES 2 X | NO | | OMPLETION OF CAUSE OF DEATH? |
| _ | DID TOBACCO U | SE CONITE | IDLITE TO CA | LICE OF DE | ATU VI | · | NO E | 11116 | EDTAIN | | | | 1 | ☐ YES 2 ☐ NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO | | IBUTE TO CA | | ACE OF DEA | | | UNC | ERTAIN | 4 RX | | _ | | |
| Sic | EXAMINER? 1 YES 2 NO | | HOSPITAL: | ER/Outpatient | 3 DOA | OTHEI 4 Nur | R: | 5 🗆 Re | sidence | 6 Other (Specifi | /1 | | | |
| 훒 | 27. MANNER OF DEATH | | 28a. DATE OF (Month, D | INJURY IV. Ybar) | 26b. TIM | | 28c. INJ | | | 28d. DESCRIBE I | | IRY OCCU | JRED | |
| à | | Pending Investigation | | | | М | 1 🗆 1 | ES 2 [| NO | | | | | |
| 3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 28s. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) | | | | | | | | | rte Number, | | | | | |
| COMPLET | 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| MP | (Check only | CAL EXAMINER | IAN: To the beat of i: On the beals of a | my knowledge, o | death occurs | ed at the t | lime, data | and place, | and due | to the cause(a) an | d manner | as stated | d. | and manner as stated. |
| | 29b. SIGNATURE AND TITLE | The same of the sa | | 17 | 12 | | Spinion, 0 | | NSE NUM | | | | | |
| 8 | 100 | RE | 18 | 1 | 5X | | | D011 | | BEH | | | | fonth, Day, Ybar) 21,1995 |
| 일 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUS | SEOF BEATH (IT | EM 27TT TYDA | Print) | | 2011 | | - | | | -5456 | ,-,,,,, |
| | Walter E. | Goozh, | | | | d Ro | ad, | Whea | ton, | Maryla | nd 2 | 0902 | 2 | |
| | 31. DATE FILED (Month, Day, AUG 23 | 100E | 12 HEGISTRA | R'S SIGNATURE | lall | | | | | | | | | |
| | המ מסח | 1333 | June 15 | | | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmit Panes 1.2.3 should | I the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execu | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bur | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic |

| | 1 - STATE REGISTRAR | STATE OF MA | | | NT OF HEALTH AN TE OF DEATH | D MEI | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Li | st) | - OLI | THIOA | IL OF BEATH | 2. | REG. NO | | 3. TIME OF DEATH | |
| | George (NMN) | Hagen Jr. | | | | 1 3 | MONTH D | 8 1995 | AB | |
| | 4. SOCIAL SECURITY NUMBER | | B. AGE (In yrs. lest b | irthday) IF UN | DER 1 YEAR IF UNDER 24 H | 8. 7.1 | DATE DE BIRTH | 8. 6 | BIRTHPLACE (State or Foreign | |
| | 291-22-2796 | 1 📉 M 2 🗌 F | 65 | YRS. MONTH | 8 DAYS HOURS MI | . J | month, Day, Year) | | Country) entucky | |
| _ | 9a. FACILITY NAME (If not institution, gi | | | 9b. C | TY, TOWN OR LOCATION O | F DEATH | | 9c. COUNTY | | |
| FUNERAL DIRECTOR | Shady Grove Adve | entist Hosp | ital | Ro | ckville | | | Montgomery | | |
| EC | 10e. STATE 10b. COL | NTY | | 10c. CITY, TOW | N OR LOCATION | | | | 10d, INSIDE CITY | |
| PIG | Maryland Mon | ntgomery | | | | | LIMITS? | | | |
| AL | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| EB | 103 Autumn Hill | Way | | | 20877 | | | Unite | d States | |
| Į. | 11. MARITAL STATUS 1 Never Married 2 X Married | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO | | | | RIGIN? (Specify Yes | or No- 14. | RACE — American Indian, Black, White, etc. | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WA | IF YES, GIVE WAR OR DATES 1946 - 1950 | | | pecify: | ono mean, out, | | Specify: | |
| | 15. DECEDENT'S E | DUCATION | | DENT'S USUAL | OCCUPATION | | 16b. KIND OF BU | SINESS/INDITET | White | |
| COMPLETED | (Specify only highest gi | college (1-4 or 5+) | (Give | kind of work do | on and | | TOO. KIND OF BO | SINCSS/INDOS | nr | |
| AP. | 12 | | | | loning Mecha | nic | U.S. G | overnme | ent | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | | - | First, Middle, Maiden | | | |
| BE (| George Hagen | | | | | | helton | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | SS (Street end Number or R | | | | | |
| | Mary D. Hagen | | | | mn Hill Way | , Ga | | | | |
| | 20e. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 R 4 Donation 5 Other (Specify) | emoval from State | cometany cromo | tone or other play | OSITION (Name of | 1 | | CATION - City | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | TATLING | | ional Cemet | | | lington | , Virginia | |
| | 1 7.5 | TI |) _ | | eVol Funera | | | | | |
| 1 | 22 DART I Enter he die see | 07 | | 1 | O E. Deer P | ark | Dr., Gai | thersb | urg, MD 20877 | |
| | shock, or heart fallu | e. List only one ceuse | coused the deet! e on each line. | h. Do not an | er the mode of dying, | such aa | cardlec or reap | iratory arreat, | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | |
| | | Post | · f. | 1. | | | | | Interval Between Onset and Death | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | . Rest | rictive | lu lu | ing de | ie | ase. | <u> </u> | | |
| 7 | disease or condition | a. Rest. | PR AS A CONSEQUE | ENCE OF): | ing de | ies | ase. | | | |
| TION | disease or condition resulting in death) Sequentially list conditions, | a. Regt. DUE TO (0 ACCUT DUE TO (0 | PI AS A CONSEQUE | ENCE OF): | eng di | se | ase. | | | |
| CATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | B. Reg / DUE TO (O DUE TO (O | PI AS A CONSEQUE | ENCE OF): | ing sh | se | ase. | | | |
| TIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | c | PR AS A CONSEQUE | , | eng dr y frite | se | ase. | | | |
| SERTIFICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | c | / | , | eng sh y faile | ser | ase. | | | |
| AL CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | c | PR AS A CONSEQUE | ENCE OF): | eng sh | ne In Part | 1. 240. WAS AN | | | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | PR AS A CONSEQUE | ENCE OF): | eng driven | in Part | PERFOR | MED? | Onset and Death 24b. WERE AUTOPSY FINDINGS ARIAL DELE PRIOR TO COMPLETION OF CAUSE | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | PR AS A CONSEQUE | ENCE OF): | eng sh | ne ser | I. 24a. WAS AN PERFOR | MED? | Onset and Death 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO (O d. lone contributing to de | R AS A CONSEQUE | ENCE OF): | | | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions of the cause of the | d | eeth but not resu | ENCE OF): uiting in the | NO UNCERT | | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions of the condition | DUE TO (O d. IONE CONTRIBUTE TO CAU HOSPITAL: 1 N Inpetient 2 = E | SE OF DEATH 28. PLACE C | Ulting in the | NO UNCERT | AIN 🌡 | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions of the cause of the conditions of the cause o | d. DUE TO (O | SE OF DEATH 28. PLACE C ER/Outpatient 3 □ | uiting in the | NO UNCERT tk only one) ER: ursing Home 5 Residen 28c. INJURY AT WORK? | AIN A | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Mitural 5 Pending Investigation | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 D Inpatient 2 = 28a. DATE OF IN (Month, Day, | SE OF DEATH 28. PLACE (ER/Outpatient 3 20. PLACE (ER/Outp | Utting in the | NO UNCERT UNCERT UNCERT ER: Unsing Home 5 Resider 28c. INJURY AT WORK? 1 YES 2 NO | AIN A | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions or injury that initiated events resulting in death) LAST DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Matural 5 Pending | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 1 Inpatient 2 E 28a. DATE OF IN (Month, Day, | SE OF DEATH 26. PLACE (ER/Outpetlent 3 INJURY — At home, | Utting in the | NO UNCERT UNCERT UNCERT ER: Unsing Home 5 Resider 28c. INJURY AT WORK? 1 YES 2 NO | AIN A | PERFOR | NJURY OCCURE | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions in the cause of the cause of the cause of the cause of the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions in the cause of the | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 to inpatient 2 = E 28e. DATE OF IN (Month, Day, 28e. PLACE OF I building, etc. | SE OF DEATH 26. PLACE C ER/Outpetlent 3 □ SUURY Year) □ SUURY Year) □ SUURY Year) □ SUURY Year) □ SUURY At home, C. (Specify) | Uiting in the YES DF DEATH (Che DOA 4 N Bb. TIME OF INJURY M , ferm, street, fi | NO UNCERT tk only one) ER: ursing Home 5 Resider 28c. INJURY AT WORK? 1 YES 2 NO | 28d | PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW II LOCATION (Street a City or Yown, State) | NJURY OCCURE | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Mitural 5 Pending Investigation of the condition of the | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 N Inpatient 2 = E 28a. DATE OF In (Month, Day, 1 Duilding, etc. 28b. PLACE OF In building, etc. | SE OF DEATH 28. PLACE C ER/Outpatient 3 INJURY Veer) INJURY At home, C. (Specify) | Uiting in the YES DEATH (Che DOA 4 N N Sb. TIME OF INJURY M , ferm, street, fi | NO UNCERT tk only one) ER: ursing Home 5 Residen 28c. INJURY AT WORK? 1 YES 2 NO actory, office | AIN 2 28d 28f. | Other (Specify) Describe How in Location (Street a City or Town, State) | NJURY OCCURE | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation of the condition of | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 Unpetient 2 E 26e. DATE OF IN (Month, Day, 10 Duilding, etc. PLACE OF I | SE OF DEATH 28. PLACE C ER/Outpatient 3 INJURY Veer) INJURY At home, C. (Specify) | Uiting in the YES DEATH (Che DOA 4 N N Sb. TIME OF INJURY M , ferm, street, fi | NO UNCERT Ik only one) ER: 28c. INJURY AT WORK? 1 VES 2 NO Notory, office | AIN 2 28d 28f. 28f. | Other (Specify) Describe How in Location (Street a City or Town, State) | NJURY OCCURE and Number or Ri | Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D ural Route Number, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Mitural 5 Pending Investigation of the condition of the | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 N Inpatient 2 = E 28a. DATE OF IN (Month, Day, n) 28b. PLACE OF I building, etc. | SE OF DEATH 28. PLACE C ER/Outpatient 3 INJURY Veer) INJURY At home, C. (Specify) | Uiting in the YES DEATH (Che DOA 4 N N Sb. TIME OF INJURY M , ferm, street, fi | NO UNCERT tk only one) ER: ursing Home 5 Residen 28c. INJURY AT WORK? 1 YES 2 NO actory, office | AIN 2 28d 28f. 28f. | Other (Specify) Describe How in Location (Street a City or Town, State) | NJURY OCCURE and Number or Ri | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Matural 5 Pending Investigate 2 Accident Investigate 3 Suicide 6 Could not determined 4 Homicide determined 29e. CERTIFIER (Certifier (Certifier Certifier | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 b Inpatient 2 E 26a. DATE OF IN (Month, Day, 10a 26c. PLACE OF In building, etc. VSICIAN: To the best of my NER: On the basic of exam | SE OF DEATH 28. PLACE C ER/Outpatlent 3 UNURY 2 NJURY At home, c. (Specify) y knowledge, death mination and/or inve | DF DEATH (Che) DOTH DOA 4 ON BINJURY M Term, street, fi | NO UNCERT Ik only one) ER: 28c. INJURY AT WORK? 1 VES 2 NO Notory, office | AIN 2 28d 28f. 28f. | Other (Specify) Describe How in Location (Street a City or Town, State) | NJURY OCCURE and Number or Ri | Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D ural Route Number, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation of the condition of | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 b Inpatient 2 E 26a. DATE OF IN (Month, Day, 10a 26c. PLACE OF In building, etc. VSICIAN: To the best of my NER: On the basic of exam | SE OF DEATH 28. PLACE C ER/Outpatlent 3 UNURY 2 NJURY At home, c. (Specify) y knowledge, death mination and/or inve | DF DEATH (Che) DOTH DOA 4 ON BINJURY M Term, street, fi | NO UNCERT Ik only one) ER: 28c. INJURY AT WORK? 1 VES 2 NO Notory, office | AIN 2 28d 28f. 28f. | Other (Specify) Describe How in Location (Street a City or Town, State) | NJURY OCCURE and Number or Ri | Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D ural Route Number, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions of the cause of the | DUE TO (O d. ITRIBUTE TO CAU HOSPITAL: 1 N Inpatient 2 = E 28a. DATE OF In (Month, Day, 1 28b. PLACE OF I building, etc. YSICIAN: To the best of my NER: On the basic of examinating the second | SE OF DEATH 28. PLACE C ER/Outpatlent 3 UNURY 2 NJURY At home, c. (Specify) y knowledge, death mination and/or inve | Ulting in the YES DF DEATH (Che DOA OTH DOA 4 N Sb. TIME OF INJURY M , ferm, street, fi occurred at the patigation, in m | NO UNCERT Ik only one) ER: 28c. INJURY AT WORK? 1 VES 2 NO Notory, office | AIN 2 28d 28f. 28f. | Other (Specify) Describe How in Location (Street a City or Town, State) | NJURY OCCURE and Number or Ri | Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D ural Route Number, | |



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an area of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE REGISTRAR

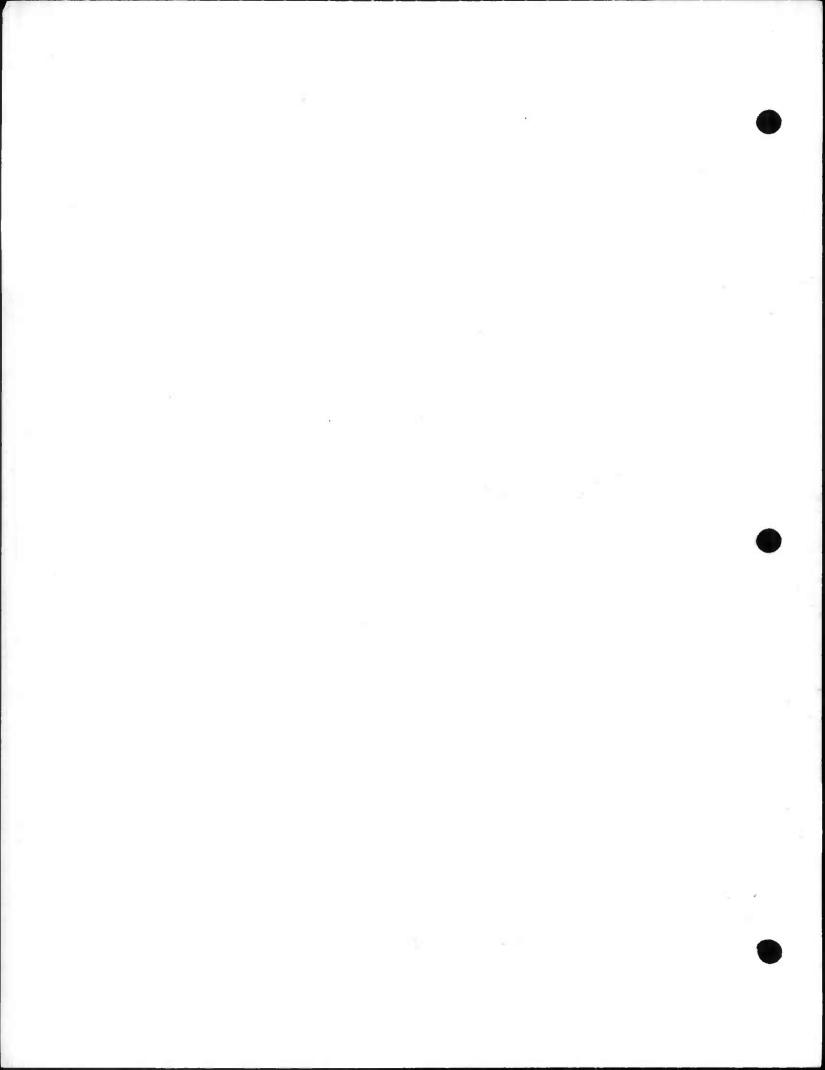
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| _ | REGISTRAR | CERTIFI | CATE OF | DEATH | REG. NO | | | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------|---------------------------------|-----------------------------------------------------|---------------------------------------------|--------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Agnes T. Hoffma | | | | | 2 9 | SEAR S 45 PM | | |
| | 216-10-9640 1□ № 2 🖾 1 98 | yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) MARCH 7,1 | | BIRTHPLACE (State or Foreign Country) INDIANA | | |
| OR | 99. FACILITY NAME (If not institution, give street end number) BEDFORD COURT HEALTH CARE | | 96. CITY, TOWN OR LOCATION OF GEATH SILVER SPRING | | | | Y OF OEATH TGOMERY | | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | I soc CITY | TOWN OR LOCA | TION | | | AND MINISTER OF THE | | |
| L DIRECTOR | MARYLAND MONTGOMERY 100. STREET AND NUMBER | | ILVER S | PRING | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 3701 INTERNATIONAL DRIVE | | 1 | 20906 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS GECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | If yee, s | | NC ORIGIN? (Specify Yenn, Puerto Rican, atc.) | s or No- 14 | Specify: WHITE | | |
| 유 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16s. DECEDENT'S | JSUAL OCCUPAT | ON | 16b. KIND OF BU | SINESS/INDUS | TRY | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 +) 12 4 | TEACH | ork done during m retired.) IER | ost of working | EDUCAT | ION | SCH00LS | | |
| | 17. FATHER'S NAME (First, Middle, Last) MATHIAS HOFFMAN | | | 18. MOTHER'S NA | ME (First, Middle, Melden WALTZ | Surname) | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) HOWARD ECHTERLING | 196. MAILING 19403 | ADDRESS (Street CLARK I | and Number or Rural ROAD LOW | Poute Number, City or Tow ELL, INDIAN | m, Stere, Zip Co | 46356 | | |
| | | PLACE AND DATE O | | | DATE 20c. LO | CATION CIT | y or Town, State PRING MD. | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Les) | MURI | NP ADDRESS OF FA | BER FUNERA | AL HOMI | E 20882 | | |
| | 23. PART I. Enter the diseases, or complicatione that ceused | the death De- | | | LAYTONSV | | | | |
| | ehock, or heert fellure. Liet only one ceuse on ear IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Arthur 5 | ch line. | o He | | Disease | | Approximate Interval Between Onset and Death | | |
| NOI | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due To (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CAT | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| 1 1 | PART II. Other significent conditions contributing to deeth bu | t not resulting in | the underlyle | o cause alvea la | Part I. 24a, WAS AN | ALITODEV | 24b. WERE AUTOPSY FINDINGS | | |
| EDICAL | Demantia | | | 9 00000 91011 111 | PERFOI | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| Σ ; | DID TOBACCO USE CONTRIBUTE TO C | AUSE OF | DEATH Y | ES NO | _ | | 1 TES 2 NO | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. F | LACE OF DEATH (Ch | eck only one) | | | | |
| S | 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpat | tient 3 🗆 DOA | OTHER: | ne 5 🗆 Residence | 8 Other (Specify) | | | | |
| BY PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation | 28b. TIME INJU | OF 28c. IN | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW | NJURY OCCU | RED | | |
| ETED B | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY building, stc. (Specification) | At home, farm, st | reet, fectory, offi | ce | 28f. LOCATION (Street City or Town, Stete) | | Rural Route Number, | | |
| COMPLE | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination | | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER Man | mo | | 29c. LICENSE NUI | 3357 | 29d. DATE S | BIGNED (Month, Day, Year) | | |
| 2 | Tonathan Mush | TH (ITEM 27) (Type, | | e Wisco | usin Ave | Ch | eny Chese md | | |
| | 31. DATE FILED (Month, Day, 1997) AUG 25 1995 | roll | | | | | 20852 | | |

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| | 1 - STATE REGISTRAR | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | E OF DEATH | | YEAR | 3. TIME OF DEATH | _ |
| | WALTE | | JON | ES | | | | | AL | THUST S | 10 | 195 | 1745P | м |
| | | | | | n yrs. lest birthday | | | IF UNDER 24 HRS. | 7. DATI | | | 8. BIRTH Country | PLACE (State or Foreign | |
| | 238-03-5294 | 11 0 | | | | | | | 03- | 00 00 00 | | | th Carolir | ıa |
| œ | 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH | | | | | | | | | | | | | |
| 18 | RESIDENCE OF DECEDENT | | | | | | | | | e | | | | |
| DIRECTOR | 10a. STATE MD | 10b. COUNT | | | | TY, TOWN DR | | ON | | | | | 10d. INSIDE CITY | |
| | | Bali | timore | | Ba | ltimor | e | | | | | | XX YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 727 Brookmou | nt Dr | ivo | | | | | ZIP CODE | | | | | HAT COUNTRY? | |
| NE | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | | | 1207 | | | USA | | | |
| | 1 Never Married 2 1 | Married | FORCES? 1 | YES | 2 NO | If y | es, spec | NDENT OF NISPAI city Cuban, Maxica | in, Puerto | | s or No | | - American Indian, White, etc. | |
| BY | 3 Widowed 4 Divor | rced | IF 125, GIVE 9 | WAR OR DA | 11 ES | 16 | YES 2 | 2 NO Specif | y: | | | Specit | ₿Lack | |
| E | | EDENT'S EDU | | | 16a. DECEDENT | S USUAL OCCU | UPATION | of working | 16 | b. KIND OF BU | SINESS/INDL | JSTRY | | |
| | Elementary/Secondary (0- | -12) | College (1-4 or 5 | +) | We. Do NOT | use retired.) | my most | or worning | | | | | | |
| COMPLET | NA 17. FATHER'S NAME (First, Mic | Infelia di anti | | | Indus | trial | | | | Indust | | | | |
| E C | for 1 | nes | | | | | | Ella Jo | | Middle, Maiden | Sumame) | | | |
| Ω | 19a. INFORMANT'S NAME (Ty | | | : | 19b. MAILIN | G ADDRESS (S | Street end | | | nhar City or Tow | rn State Zin / | Cordel | | _ |
| 5 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Pettaway 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6727 Brookmount Drive Baltimore, MD 21207 | | | | | | | | | | | | | |
| | 29a. METHOD OF DISPOSITION DATE 20c. LOCATION — City or Town, State | | | | | | | | | | | | | |
| | 4 Donation 5 Other | (Specify) | in. | B | irchwoo | | | | 8-2 | | Roxbor | | | |
| | 21. SHOMATURE OF FUNERAL SERVICE LICENSEE 22. MAME AND ADDRESS OF FACILITY HESTER-Whitted-Daye, Roxboro, NC 27573 | | | | | | | | | | | _ | | |
| | hester-whitted-Daye, Roxboro, NC 27573 | | | | | | | | | | | | | |
| | | leg | 1/100 | for | | | | | | | | | NC 27573 | |
| | 23. PART Lenter the dis | senses fr | complications that | t caused | the death. Do | | | | | | | | Approximate | _ |
| | IMMEDIATE CAUSE (Fine | sart tagore. | List only one cau | ise on ea | ich iine. | not enter the | e mode | e of dying, suc | h aa car | rdiac or reapi | iratory arre | | | |
| | MIOCK OF HE | sart tagore. | A CUT | ISE ON ea | My c | not enter the | e mode | | h aa car | rdiac or reapi | iratory arre | | Approximate interval Between | th |
| _ | IMMEDIATE CAUSE (Find disease or condition | sart tagore. | A CUT | ISE ON ea | ich iine. | not enter the | e mode | e of dying, suc | h aa car | rdiac or reapi | iratory arre | | Approximate interval Between Onset and Dea | th |
| NOL | IMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition | al + | a. A C UT | (DR AS A | My c | not enter the | e mode | e of dying, suc | h aa car | rdiac or reapi | iratory arre | | Approximate interval Between Onset and Dea | th |
| CATION | IMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN | oris, I | a. A C UT | (DR AS A | CONSEQUENCE | not enter the | e mode | e of dying, suc | h aa car | rdiac or reapi | iratory arre | | Approximate interval Between Onset and Dea | th |
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| ERTIFICATION | IMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLYIN CAUSE (Disease or Injur | al + | a. A C U TO DUE TO | (DR AS A | CONSEQUENCE | not enter the | e mode | e of dying, suc | h aa car | rdiac or reapi | iratory arre | | Approximate interval Between Onset and Dea | th |
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| COMPLETED BY PHYSICIAN: MEDICAL C | MMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or Injury) PART H. Other significent that injury in death) LAST DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER DF DEATH 1 Netural 5 P 2 Accident 3 Suicide 6 C 4 Homicide 6 C 29a. CERTIFIER (Check only one) 2 MEDIC | ons, liste and condition of the conditio | DUE TO DUE TO DUE TO DUE TO DUE TO RIBUTE TO CA RIBUTE TO CA POSITIAL: 1 28e. PAACE OF (Month, D. 28e. PAACE OF building, D. 28e. PAACE OF SER: Do the best of series of | (OR AS A (OR AS A (OR AS A (OR AS A (DR AS A | CONSEQUENCE CONSEQUENCE CONSEQUENCE It not resulting The PLACE OF DE Itlent 3 □ DOA 28b. Ti H At home, farm, | not enter the | or model. | Cause given in UNCERTAIN 5 Residence TY AT TS 2 ND | Part i. 8 Oth 28d. DE 28l. LOC/hy to line ca | 24a. WAS AN PERFOR 1 YES 2 CATION (Street a or Town, State) | AUTOPSY MED? NO NJURY OCCU | 24b. JRED r Rural Ro | Approximate interval Betwee Onset and Des IS IN I I I I I I I I I I I I I I I I I | th 7 |
| BE COMPLETED BY PHYSICIAN: MEDICAL C | DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 Netural S P 2 Accident S 2 Accident S 2 Accident S 2 MEDIC 29b. SIGNATURE AND TITLE (A | one on the condition of the conding | DUE TO DUE TO DUE TO DUE TO DUE TO RIBUTE TO CA HOSPITAL: 28e. DATE DF (Month, D. 28e. PLACE OF building, CIAN: To the best of exercises. | (OR AS A (OR AS A (OR AS A (OR AS A deeth bu ER/Outpa INJURY ay, Year) F (NJURY my knowle camination | CONSEQUENCE CONSEQUENCE It not resulting A PLACE OF DE At home, farm, It not resulting A consequence The place of De At home, farm, It not resulting A consequence | not enter the | or model. | Cause given in UNCERTAIN 5 Residence TY AT KY S 2 ND | Part (. S Oth 281. LOCAL to line ca | 24a. WAS AN PERFOR 1 YES 2 er (Specify) CATION (Street a or lown, State) | AUTOPSY IMED? AND NO | 24b. JRED A. Couse(s) SIGNED (| Approximate interval Betwee Onset and Dea IS IN I I I I I I I I I I I I I I I I I | th / |
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| | 9 | 1. DECEDENT'S NAME (First, Middle, Last CHARLES | EMANUEL | Jo | 10244 | N | 2. DATE MONTH | | 1995 | EAR 3. | TIME OF DEATH |
| 9 | | 4. SOCIAL SECURITY NUMBER 579-58-8590 | 1 ₹ M 2 □ F 4 7 | (In yrs. last birthda YRS | MONTHS D | EAR IF UNDER 24 HRS. AYS HOURS MIN. | 7. DATE | OF BIRTH 67194 | 8 V | BIRTHPL Country Vash | D.C. |
| 2, 3 should | стов | 90. FACILITY NAME (If not institution, give Fort Washington RESIDENCE OF DECEDENT | | | | Washingto | | | PRINCE | | |
| permit. Pages 1, | FUNERAL DIREC | 10a. STATE 10b. COUN | nce Georges | | t. Was | ocation hington | | | | 10 | d. INSIDE CITY LIMITS? YES 2 NO |
| ist. | | 100. STREET AND NUMBER 7704 Locust La | ne | | | 101. ZIP CODE 20744 | | | 10g. CITIZEI U.S.A | | T COUNTRY? |
| attending physician. se as the burial-transit | ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | II ye | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarlo Rican, etc.) 1 ☐ YES 2 ▼NO Specify: Black | | | | | hite, atc. | | |
| 5 5 | LETED | 15. DECEDENT'S ED (Specify only highest grade Elementary/Secondary (0-12) | UCATION de completed) College (1-4 or 5+) | (Give kind life. Do NO) | use retired.) | ng most of working | | KIND OF BUS | INESS/INDUS | TRY | |
| the hospital of detached for once. | COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | Police | e Offi | 18. MOTHER'S NA | | olice | | artm | ent |
| के दे | BE C | Curtis Johnson | | | | Mary | | | sumsme) | | |
| 5 should notified | TO B | 19a. INFORMANT'S NAME (Type/Print) | | | | treet and Number or Rural | | | | | |
| 2 8 0 | - | Marilyn Johnso | | | | st Ln.Ft | | | | | |
| e 6 may ector, pa must b | | 20a. METHOD OF DISPOSITION 1 © Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Cemetery 8/18/95 Landover, Md. | | | | | | | | | |
| Pag al dir | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HODGES and Edwards | | | | | | | | | |
| | | Jones Edward 3910 Silver Hill RD. Suitland, Md. | | | | | | | | | |
| 24 hours at filled in by tion, or remy the medic | | 23. FART I. Enter the disease, or shock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. METASTAT DUE TO (OR AS A | ach lina. | CINON | | | lac or reapir | atory arrest | l, | Approximate Interval Batwean Onset and Daath |
| th certificate be execuentially bysician and Hygiene prior to but or other traumati | CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. Due to (or as a consequence of): c. Due to (or as a consequence of): d | | | | | | | | | |
| at the c by the and Me y injur | MEDICAL (| PART II. Other algnificant condition | one contributing to death b | out not resultin | g in tha undar | ilying cauaa givan in | Part I. | 24a. WAS AN / PERFORI t YES 2 | MED? | AW | RE AUTOPSY FINDINGS IILABLE PRIOR TO MPLETION OF CAUSE DEATN? |
| v requires the been signed it, of Health | : ME | DID TOBACCO USE CON | TRIBUTE TO CAUSE O | E DEATH | YES II NO | UNCERTAI | N IST | | | | YES 2 NO |
| has Dep | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DI | EATH (Check only | | La | | | | |
| PHYSICIAN: The this certificate I with the State | YSI | 1 TYES 2 XNO | HOSPITAL: 1 Inpatient 2 ER/Outp | - 1 | | Nome 5 Residence | 6 🗆 Other | (Specify) | | | |
| | ву рн | 27, MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | | | M 1 | WORK? | 28d. DES | CRIBE HOW IN | JURY OCCUR | IED | |
| OR ATTENDING DIRECTOR: After hours after death item 28 is ma | ETED | 3 Suicide 6 Could not be 4 Homicide detarmined | 28a. PLACE OF INJURY building, etc. (Spec | — At home, tem | n, street, lactory, | offics | 281, LOCA City o | ATION (Street er or Town, State) | nd Number or i | Rumi Floute | Number, |
| 7 70 = | COMPL | one) 2 MEDICAL EXAMIN | SICIAN: To the best of my know IER: On the basis of exemination | | | | | | | auso(s) an | d manner as stated. |
| TO THE HOSPITY TO THE FUNERA DE filed within 7 IMPORTANT: 1 | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIE | | | | | 29c. LICENSE NUMBER D25925 Aug 15, 1995 Ave, Bethesd2, Md 20814 | | | | 1995 |
| 5) | | 30. NAME AND ADDRESS OF PERSON W J. BERGER MD | # 205 , 77 | ATH (ITEM 27) (T): 20 WISC | pe, Print) CONSIN | Ave, BeTI | rosd | 2, M | d 2 | 081 | 4 |
| | | AUG 23 1995 | 32 HEGISTHAR'S SIGN | ATURANAK | | | | | | | |

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for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transpendent with the State Dent of Health and Mental Hudian prior in burial common or named. | natic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certi- | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fit he filed within 70 hours after death with the State Denir of Health and Mental Hunians ador to huital cremation, or seminal | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

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| | 1 - STATE REGISTRAR | STATE OF MA | RYLAND / | OEPAR ERTIF | TMENT OF | F HEALT | H AND | MENTA | L HYGIEI | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Lest) | Jenki | 15 | | | | | 2. DATE | OF DEATH | T G | YEAR | 3. TIME OF GEATH | N |
| | 4. SOCIAL SECURITY NUMBER 229 36 7263 | 5. SEX 6. | MONTHS DAVE HOUSE SEEM (| | | | | 7. DATE (Mort | OF BIRTH M, Day, Year) 12, | 1933 | Count | HPLACE (State or Fore | _ |
| DR. | On. FACILITY NAME (If not institution, give s University of Man | , | pital | | 9ь. СІТУ, ТОУ Ва | n on Local | | | . 12, | _ | INTY OF D | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | 10c. CITY, TOWN OR LOC | | | | | ATION | | | | | 10d. INSIDE CITY | |
| | Maryland Anne 100. STREET AND NUMBER 1063 Springhill V | Arunde1 | 10f. ZIP CODE | | | | | | | 10g. CIT | IZEN OF | 1 YES 2\ N | 0 |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT E | 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 Pyes 2 NO If yes, specify Cuben, Maxican | | | | | NIC ORIGIN | 17 (Specify Ye | | | States E — American Indian, k, White, etc. | , |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR | OR DATES | | 10 | YES 2XTXN | | 'ly: | | | Spec | | |
| COMPLETED | (Specify only highest grade | College (1-4 or 5+) | (Gi | tve kind of v Do NOT us | USUAL OCCUP vork done during se retired.) | | rking | | KIND OF BU | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Grover Earl Jenk: | |] Owi | ner | | | | AME (First, | Jenkir Middle, Maider e Mass | Sumame) | sulai | tion Co. | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Hazel L. Jenkins | 0115 | 19b | | ADDRESS (Sm | et and Numb | per or Rural | Route Num | ber, City or Tox | vn, State, Zij | | 05/4 | |
| | 20a, NETHOD OF DISPOSITION 1 Description March Description Percentage Description Percentage Description Percentage Description Descriptio | oval from Stata | cemetery cres | ND DATE C | FOISPOSITION | (Name of | | DAT | E 20c. L0 | OCATION — | City or To | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | THATYL | B | 22. NAMI Rot | ert] | E. Ev | ans | Funera | al Ho | me, | P.A. | |
| | 23. PART i. Enter the diseases, or c shock, or heart fellure. | complications that c | oused the day | ath. Do n | ot antar the | 000 At | nnapo lying, suc | lis ch ss cere | Rd. Bo | owie | Md | Approximate interval Bets | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Biven | barel | W | Center | • | | | | rn. | 001 | Onset and C | Seath |
| NO | Sequantially list conditions, | myse | AS A CONSEC | l i | nlave | ben | 0 | NPF | RO) | AD. | 00 | A. | |
| RTIFICATION | if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | AS A CONSEC | | | 4 |),(. | / | 1 forty | 10 | F | | |
| CERTI | resulting in death) LAST | 1. | | | | 11/2 | Con Marie | Althor Indenda | 90v | 1,6hr | ر قار | | |
| PHYSICIAN: MEDICAL | PART II. Other significant condition | contributing to da | eth but not re | esuiting l | n the underl | ing cause | given in | Part I. | 24a. WAS AN PERFO | RMEO? | 24b | WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? | |
| AN: M | DID TOBACCO USE CONTR | RIBUTE TO CAUS | | | | | CERTAI | NΝ | | , | | 1 YES 2 NO | |
| YSICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | | | | | |
| ВУ РЬ | 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | | | | | | | | 28d. DEŞCRIBE NOW INJURY OCCURED | | | | |
| | 3 Suicide 6 Could not be detarmined | 28a. PLACE OF IN building, atc. | . (Specify) | | | | | City | ATION (Street or Town, State |) | | loute Number, | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSIC (Check only one) 2 MEDICAL EXAMINEI | CIAN: To the best of my R: On the bests of exam | | | | | | | | | |) and manner as state | ed, |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 11101 | | | | 29c, LI | CENSE NU | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) | |

2 MEDICAL EXAMINER: On besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OP CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

J.McLaughlin M.D. 22 S. Greene St. Balt. Md. 21201

D 08197

AUG 25 1995

3. TIME OF DEATH

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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orma hans August 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthdey) 6. BIRTHPLACE (State or Foreign Country) MARYLAND IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH APR. 15,1923 213-18-4127 1 M 2 X F 72 DAYS HOURS YRS Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 96. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY CO. RESIDENCE OF DECEDENT 10a, BTATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. BALTIMORE CITY BALTIMOIRE 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 600- LIGHT STREET #918 21230 U.S.A. use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XXNO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, While, atc. If yes, specify Cuban, Mexican, Puerlo Ricen, etc.)

1 YES 2 X XO Specify: 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES Specify: WHITE BY 3 Widowed 4 Divorced ETED I 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Sp funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 SECRETARY NOT AVAILABLE once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'B NAME (First, Middle, Meiden Surna NOAH B. SINCLAIR BERTHA JANE WILSON H BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9701- VEIRS DRIVE, ROCKVILLE, MD. 20850 2 REV.DR. RICHARD REICHARD ag Pe 20e. METHOD OF DISPOSITION

1X Burlel 2 Cremetion 3 Removal from State death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 1X Buriel 2 ☐ Cremetion 3 ☐ .
4 ☐ Donation 6 ☐ Other (Specify) _ must CEMETERY

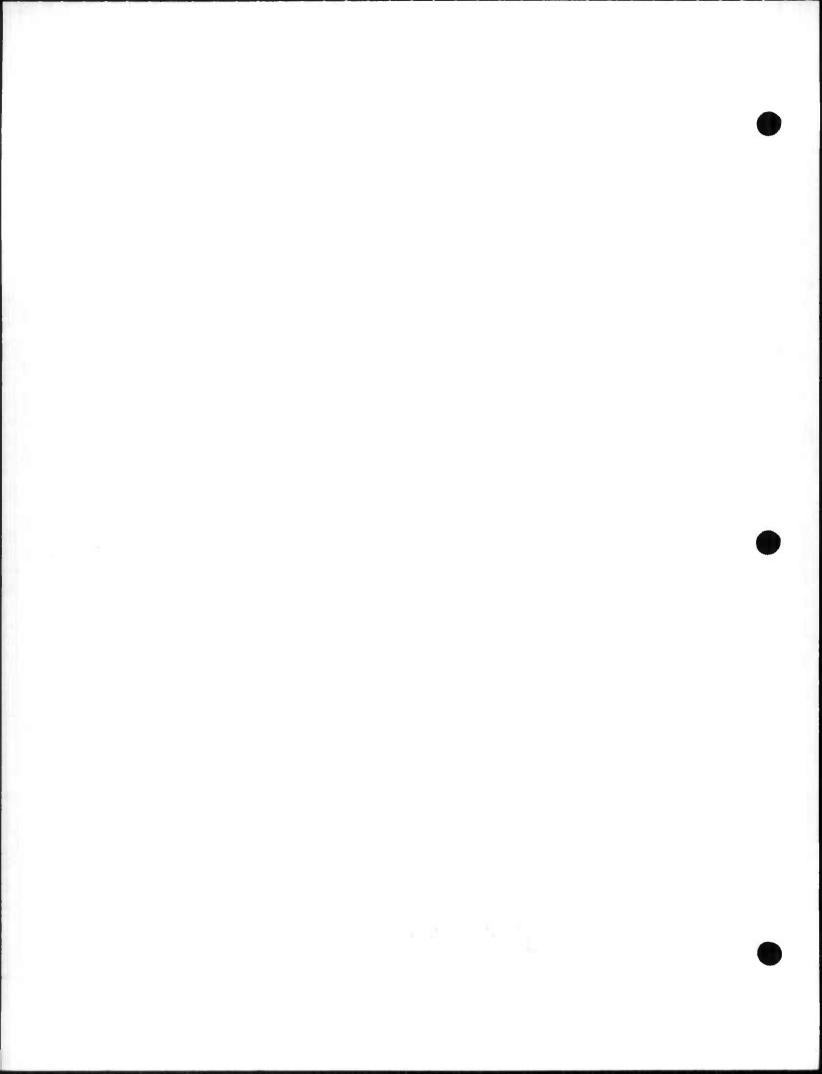
CEMETERY 8/21 GLEN BURNIE, MD. examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HYSONG CO., INC. Hyson cuted within 24 hours after de d completely filled in by the fu urial, cremation, or removal. 1300- N ST., NW, WASH., DC medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ neumonia resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) n and com to burial, c executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate death certificate be attending physician prior cause. Enter UNDERLYING CAUSE (Disease or injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 signed by the atte Injury. PART it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Congestive T-ailuse requires that any 1 YES 2X NO shows 2 Phoematord 1 YES 2 NO been f. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO XX UNCERTAIN PHYSICIAN: State Dept. 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) ftem HOSPITAL: OR ATTENDING PHYSICIAN: 1 TES TONO Nursing Nome 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA the 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this c 26d. DESCRIBE HOW INJURY OCCURED marked, Netural 5 Pending 1 YES 2 NO BY After Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after di .00 6 6 Could not be 4 Nomicide COMPLET hours Item 29e. CERTIFIER
(Check only one)

2 MEDICAL FXAMINES: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end menner as stated. HOSPITAL FUNERAL within 72 I TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date end pieca, and due to the cause(s) and menner ea stated. 29d. DATE SIGNED (Month) MATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER BE 9 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12850 Middlebrook er Mb anie

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2. DATE OF DEATH MONTH

W



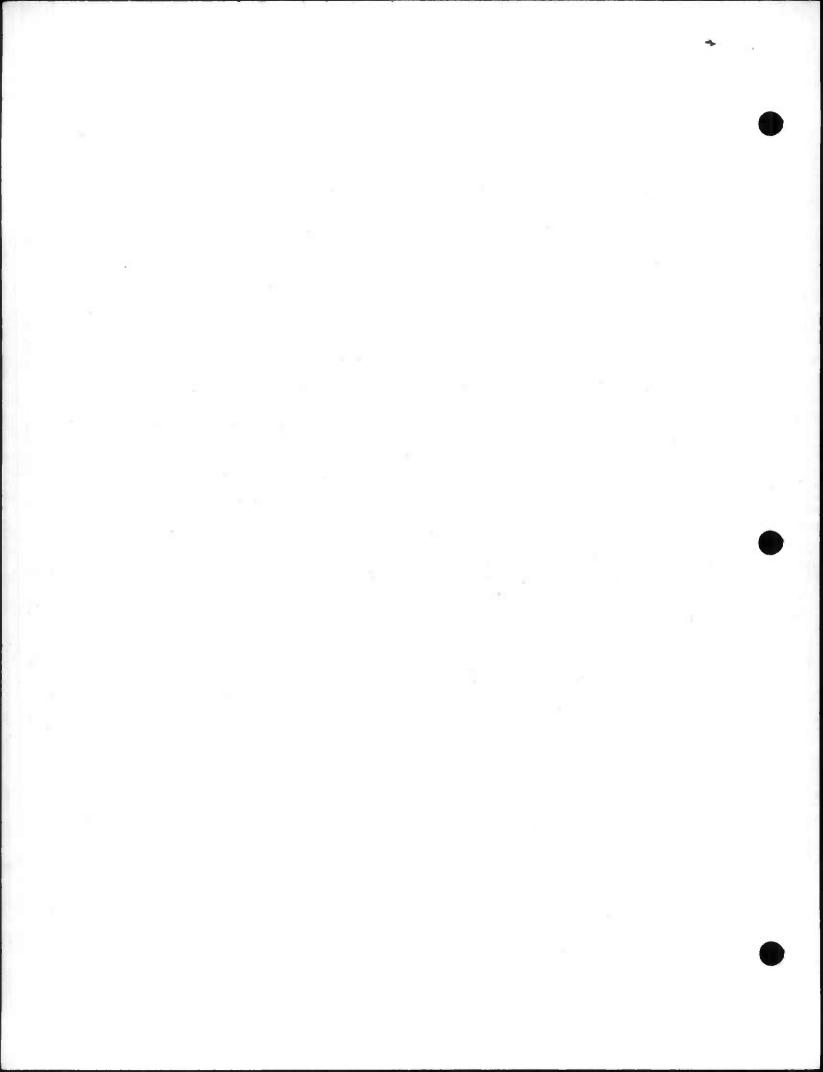
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S, NAME (First, Middle, Last) . DATE OF DEATH 3. TIME OF DEATN shuson 7100 olanda ugust 4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 0/2 B. BIRTHPLACE (State or Foreign Oct. 18, 579-98-7228 1964 WASHINGTON, D.C. 1 M 2 KW 30 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5104 Emo St., DIRECTOR Captiol Heights Prince Georges RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 1 XXYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5104 Emo St., 20743 UNITED STATES funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— H was specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. Specify: BLACK BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerto Rid 1 YES 2 P NO Specify: Married 2 Married BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11 FOOD SERVICE EDUCATIONAL 17. FATNER'S NAME (First, Middle, Last) AL 1 0/40 18. MOTNER'S NAME (First, Middle, Maiden Surname) Ħ ALPHONZP JOHNSON RAMONA PROCTOR BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RAMONA E. PROCTOR JOHNSON 5104 Emo St., Captiol Height, Md. 20743 hours after death. Page 6 may be e 20a METNOD OF DISPOSITION

12 Puriel 2 ☐ Cremetton 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must "HARMONY "MEMORIAL PARK 8/22 Landover, Md. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES ALEXANDER S. POPE FUNERAL HOMES M859 2617 Penn. Ave., S.E., Wash., D.C. and completely filled in by the to burial, cremation, or removal. medical 23. PART i. Enter the diseases, or complications shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batween ation, or **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition_ Tregund DUE TO (OR AS A CONSEQUENCE OF): syndram event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 if any, leading to immediate the attending physician I Mental Hygiene prior to the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the any 1 - YES 2 - NO OF OEATH? 1 YES 2 NO L of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN [has b DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) certificate h 1 PES 2 NO HOSPITAL OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Mesidence 6 Other (Specify) 10 27. MANNER OF DEATH (Monte, Pay, Year) N/A 28c. INJURY AT N/A 28d. DESCRIBE NOW INJURY OCCURED marked, this c 1 Natural N/A 1 YES 2 NO BY After t 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify), 7 / A 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3.7 / A 3 Suicide -ETED 6 Could not be DIRECTOR: / 4 Homicide N/A 28 determined N/A Item 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my online, death occurred at the time, date and class and due to the COMPL TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 ho (Check only one) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated, D21230 NUMBER 29d, DATE SIGNED (Month, Day, Year) BE ALLAUST 16 2 Rodriguez, Rayburn Ct., Camp Springs, MD 29748 31. DATE FILED (Month, Day, Year) AUG 22 1995

| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | Į |
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| | 1 - STATE OF MA | | TMENT OF HEALTH AND ICATE OF DEATH | MENTAL HYGIEN | E | | | |
| | 1. DECEMENT'S NAME (First, Middle, Last) | soves | MS | | S. 1948 3. TIME OF DEATH | | | |
| DIRECTOR | 4. SOCIAL SECURITY NUMBER 5. SEX 6. 215-22-2813 1X M 2 F | F 70 YRS. MONTHS DAYS HOURS MIN. | | (Month, Day, Year) Country) | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | 70 | 9b. CITY, TOWN OR LOCATION OF D | | 25 Pennsylvania | | | |
| | Carroll County General Hospit | | Westminster | • | Carrol1 | | | |
| IRE | Maryland Carroll | | y, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | |
| | 104. STREET AND NUMBER | ne. | 101, ZIP CODE | | 1 YES 2 NO | | | |
| FUNERAL | 121 Warfieldsburg Rd. | 21157 | | United States | | | | |
| 2 | 11. MARITAL STATUS 12. WAS DECEDENT E | VER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No. 14. RACE - American Indian. | | | |
| BY F | 3 Widowed 4 Divorced IF YES, GIVE WAR | OR DATES | If yes, specify Cuban, Maxica | | to Rican, etc.) Black, White, atc. Specify: | | | |
| ED B | 15. DECEDENT'S EDUCATION | | USUAL OCCUPATION | T | white | | | |
| COMPLETE | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | He. Do NOT us | vork done during most of working le retired.) | | BINESS/INDUSTRY | | | |
| P P | 7 17. FATHER'S NAME (First, Middle, Last) | Electr | | | ractors | | | |
| BE CO | Henry Clinton Jone | S | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pheobe Leona Pierce | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | ADDRESS (Street and Number or Rural | | 2223. | | | |
| | Mary T. Jones | 121 W | arfieldsburg | Rd., Wes | | | | |
| | 1X Burlel 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) | cemetery, cremetory or of | OF DISPOSITION (Name 8/30/9 | | CATION — City or Town, State | | | |
| 1 8 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| | Pritts Funeral Home & Chapel | | | | | | | |
| PHYSICIAN: MEDICAL CERTIFICATION | 23. PART I. Enter tha diseases, or complications that coused had deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on asch line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| | PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 YES 2 NO 246. WERE AUTOPSY FINDS AMILBLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | | | | | | | |
| Ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | |
| HYS | 1 ☐ YES 2 ☐ NO 1 ☐ Inpatient 2 ☐ E 27. MANNER OF DEATH 25s. DATE OF IN. | R/Outpatient 3 DOA JURY 26b. TIM | 4 - Nursing Home 5 - Rasidenca | 8 Other (Specify) 28d. DESCRIBE HOW II | HIBY OCCUPED | | | |
| | Natural 5 Pending (Month, Day, | | JURY OCCURED | | | | | |
| ED BY | 3 Suicide 28s. PLACE OF II | 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, offica City or Town, State) | | | | | | |
| <u> </u> | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the heat of the brownedge death accurred the life day. | | | | | | | |
| COMPLET | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated, Officek only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | |
| TO BE CO | 296, STENATURE AND TITLE OF CERTIFIER 296, LICENSE NUMBER 296, LICENSE NUMBER 296, DATE SIGNED (MONTH, Day, Year) AUGUST 28, 19 45 | | | | | | | |
| | 200 Memorial Avenue, Westminster, MARYLAND 7-1157 | | | | | | | |
| | 31. DATE FILED (Month, Day, Voar) 32. REGISTRAR'S SIGNATURE | | | | | | | |
| لبسا | HUUS () 1995 June 20 | nator-harvell | | | | | | |



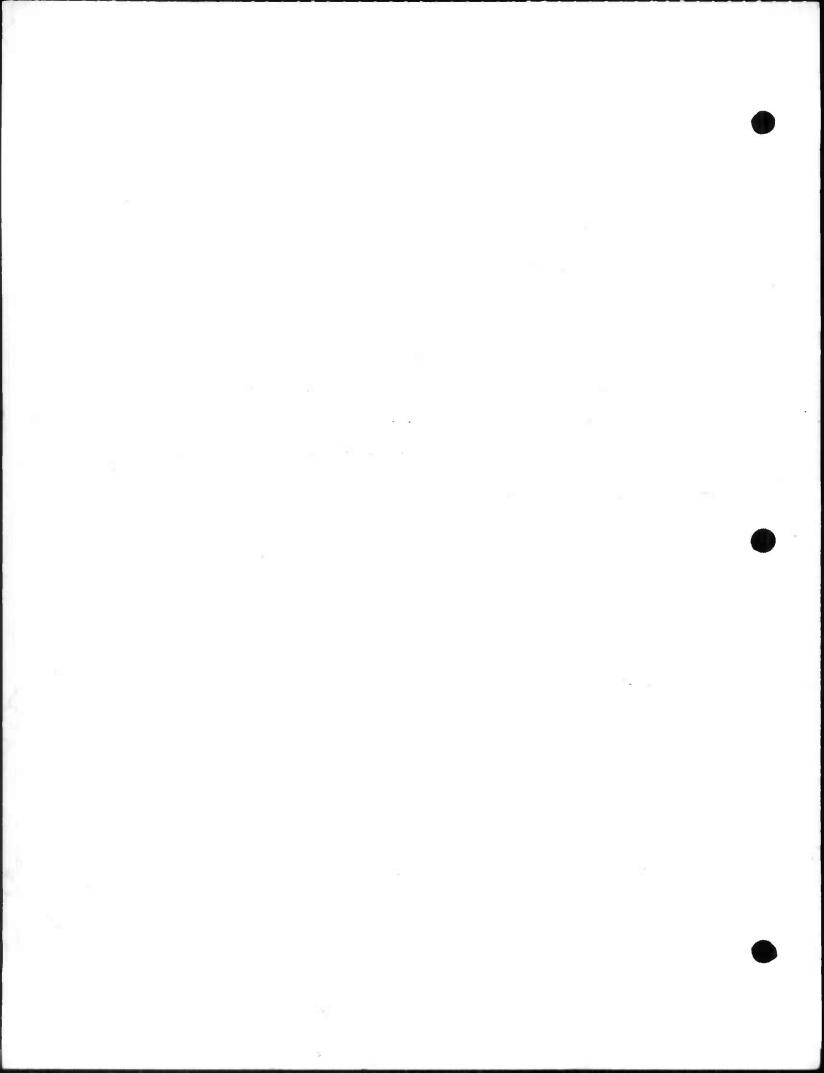
| | | HEGISTHAR | CERTIFICATE C | F DEATH | REG. NO. | | | | | |
|--------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------|--|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | JONES | | DATE OF DEATH DAY | 3. TIME OF OEATN | | | | |
| | | 4. SOCIAL SECURITY NUMBER 218-32-5278 1 | 6. AGE (In yrs. lest birthday) F UNDER 1 YEA 57 YRS. MONTHS DAY | IR IF UNDER 24 HRS. 7. | OATE OF BIRTIN (Month, Pay, Year) 9 18 37 | 8. BIRTNPLACE (State or Foreign Country) Maryland | | | | |
| 3 should | - | 9e. FACILITY NAME (If not institution, give street end number) | | N OR LOCATION OF DEATH | 9c. COU | NTY OF OEATN | | | | |
| 1, 2, 3 | 5 | Univ. of Maryland Medical Centr. Baltimore n/a | | | | | | | | |
| permit. Pages 1 | DIRECTOR | 100. STATE 10b. COUNTY MD Carroll | 10c. CITY, TOWN OR LO | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | | |
| permit | | 10e. STREET AND NUMBER | 1.71 | 101. ZIE CODE | 10g. CITI | ZEN OF WHAT COUNTRY? | | | | |
| | FUNERAL | 1515 Deer Park Ro | | 21048 | U | SA | | | | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit | Æ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDER FORCES? IF YES, GIVE V | 1 YES 2 NO If you | DECENDENT OF HISPANIC Of specify Cuben, Mexican, Pures 2 NO Specify: | RIGIN? (Specify Yes or No— perto Ricen, etc.) | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 215-0 attending se as the | 8 | 15. GECEDENT'S EOUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUAL OCCUP (Give kind of work done during | | 16b. KIND OF BUSINESS/INC | DUSTRY | | | | |
| fal or lifer u | COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 | life On NOT use retired t | aring most or working | | | | | | |
| AND 2. the hospital of detached for | NO MP | 12 17. FATNER'S NAME (First, Middle, Last) | operator | | | vater plant | | | | |
| VLA be de | 6 m | Edwin Stewart Jones | | The state of the s | First, Middle, Melden Surname) Livia Stock | redale | | | | |
| MAR retained 5 should |) BE | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING AOORESS (Stre | | Number, City or Town, State, Zip | | | | | |
| De res | | Phyllis Jean Jones | 1515 Deer | Park Rd., | Finksburg, | MD 21048 | | | | |
| ORE, | | 20s. METHOD OF DISPOSITION 1 Disposition 3 Removal from State | 20b. PLACE AND DATE OF OISPOSITION cemetery, crematory or other place) | (Name 8/29/95 | OATE 20c. LOCATION - | City or Town, State | | | | |
| Page 6 | | 1 Donation 5 XOther (Specify) entombme: 2 Signature of Funeral, Service Licensee | | erlea, Maryland | | | | | | |
| BALTIMORE, or death. Page 6 may be the funeral director, page | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, | | | | | | | | |
| B nours after of in by the or removal. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | |
| y fillen, | | Interval Betwee IMMEDIATE CAUSE (Final disease or condition | | | | | | | | |
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| 6876C executed will and comple o burial, cre | | Sequentially list conditions, b. | | | | | | | | |
| ior tr | AT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| Certificate ding physical property | CERTIFICATION | CAUSE (Disease or Injury that Initiated events Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| O 5 5 7 6 | ERI | resulting in death) LAST | | | | | | | | |
| | | PART II. Other algnificent conditions contributing to | death but not resulting in the underly | /ing couse given in Part | I. 24s. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | |
| CORD ires that the signed by the leafth and M | EDICAL | | | | PERFORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| | ME | | | | | 1 TES 2 TO | | | | |
| Sept. P | Ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | |
| 一年 報報 | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Ingestent 2 | 26. PLACE OF DEATN (Check only o | | | | | | | |
| PHYSICIAN: The this certificate with the State |] > [| 27. MANNER OF DEATN 28e. DATE OF | FINJURY 28b. TIME OF 26c. | INJURY AT 26d | Other (Specify) I, DESCRIBE HOW INJURY OCC | CURFO | | | | |
| NG PHYS frer this eath with | ВУР | 1 Natural 5 Pending (Month, I | Day, Year) INJURY | WORK? YES 2 NO | 200. DESCRIBE HOW MOUNT OCCURED | | | | | |
| TISIC TTENDI TTOR: A after d | TEO . | 3 Suicide 28e. PLACE C | OF INJURY — At home, ferm, street, fectory, o, atc. (Specify) | ffice 281 | LOCATION (Street and Number City or Town, State) | or Rural Route Number, | | | | |
| DIRECT DIRECT | 7 | 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of | f my knowledge, death occurred at the time, d | ate end place, end due to the | e Cause(s) and manner so stat | 4 | | | | |
| HOSPITAL FUNERAL within 72 | COMPL | | examination end/or investigation, in my opinion | | | | | | | |
| HE FUN | U U | 296. SIGNATURE TO TITLE OF CERTIFIER | | 29c. LICENSE NUMBER | 29d. DATI | E SIGNED (Month, Day, Year) | | | | |
| TO THE HOSPITA TO THE FUNERA De filed within 7 | 0 | 1 July | | DU6015 AVE 26 1995 | | | | | | |
| | F | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU | | IRLEM, UNI | OF MANIEN | 0 | | | | |
| | | 31. DATE FILED (Month, Day, Year) 32. REGISTRA | AB'S SIGNATURE | Brame, | | | | | | |
| | | | Thurson Kardall | | | | | | | |
| | | 1000// | | | | | | | | |

physician. burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death, Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | | |
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| uted with | complet | inal, crer | c even |
| be exec | ician and | ior to bu | raumat |
| ertificate | ing phys | ygiene pi | other |
| e death o | he attend | Mental H | jury, or |
| s that th | ned by th | Ith and I | any In |
| require: | been sign | t. of Hea | shows |
| . The lav | sate has | tate Dep | Item 23 |
| IYSICIAN | is certific | ith the S | ed, or |
| DING PF | After th | death w | s mark |
| IR ATTEN | RECTOR | rurs after | 82 mg |
| SPITAL D | ERAL DI | nin 72 ho | TT: 11 10 |
| THE HOS | THE FUN | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. |
| 2 | 2 | 8 | ≊ |

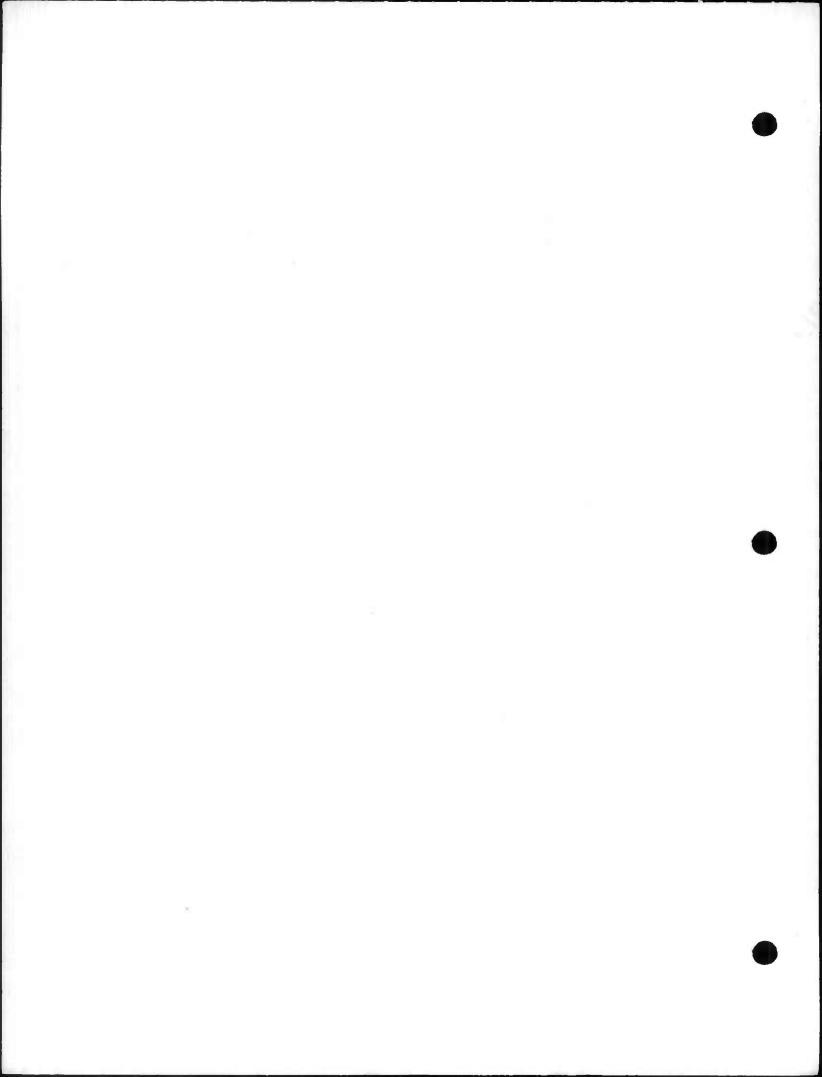
| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | TMENT OF I | EALTH AND | MENTAL | HYGIENE REG. NO. | • | | | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------|-------------------------------------|----------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------|---------------------------------------------------|------------|-------|---------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE C | F DEATH | H 3. TIME OF DEATH | | | |
| FUNERAL DIRECTOR | Robert E. | Jones | | | | Augu | C.T | 16 199 | AR S | :32 | Д м |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| in yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE O | | 8.1 | BIRTHPLACE | | Foreign |
| | 579-30-1028 | 1 XM 2 🗆 F | 69 YRS. | MONTHS DAYS | HOURS MIN. | | /17/25 | N. W. | shing | ton, | D.C. |
| | 9a. FACILITY NAME (If not institution, give str | eet and number) | | 96. CITY, TOWN | OR LOCATION OF D | | 11/11 | 9c. COUNTY | OF DEATH | | |
| | Atlantic General Hospital Berlin | | | | n | | | Wor | rceste | r | |
| | RESIDENCE OF DECEDENT | | | Y, TOWN OR LOCA | ION | | | | | | |
| | LAID D | | | eltsville | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 N | | | |
| | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | 10g. CITIZEN OF WHAT COUNTRY? | | |) NO |
| | 1010 Greenmount Ave. | | | | 20705 | | | USA | | | |
| S | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | | | 13. WAS DEC | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye | | | es or No. 14. RACE — American Indian, | | | lien, |
| BY F | 1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1 0 A A 1 0 A 5 | | | | If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 XNO Specify: | | | Black, White, atc. Specify: | | | |
| | | 1944-1945 | | | | | | | wl | nite | |
| TE | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION :ompleted) | (Give kind of v | USUAL OCCUPATION ork done during me | | 16b. I | CIND OF BUS | INESS/INDUST | RY | | |
| 벌 | Elementary/Secondary (0-12) | Elementary/Secondary (0-12) College (1-4 or 5 +) 12 2 Foreman of 7 | | | id.) | | | | in Co | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | or irans | Trans. Dept. Utility Co. 16. MOTHER'S NAME (First, Middle, Melden Surname) | | | | | | |
| | Charles W. Jones | | | | | | | iurname) | | | |
| BE | 194. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | Sylvia Stoner (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | |
| 5 | Marion M. Jones | | | | int Aven | | | | | and 2 | 0705 |
| | 20a. METHOD OF DISPOSITION | 20b | PLACE AND DATE | OF DISPOSITION (N | me of | DATE | _ | ATION — City | | | 0703 |
| | 1 Buriel 2 Cremation 3 Ramo | val from Stata cem | ort Linc | oln Cem | eterv | 18/19/ | | | | | |
| | Burlet 2 Cremetton 3 Removed from State Commettery Commettery Brentwood MD | | | | | | | ome | | | |
| | 11800 New Hampshire Avenue | | | | | | , | | | | |
| | Silver Spring, Maryland 20904 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | nete: | | | |
| | shock, or heart fellure. List only one cause on each line. | | | | | | | | | | |
| | IMMEDIATE CAUSE (Finel disease or condition Constant Death Constan | | | | | | | | | | |
| | resulting in death) a. CFREBIG VASCINAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | SAKS | | |
| z | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 5 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | |
| E | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| 5 | d | | | | | | | | | | |
| | PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS | | | | | | | | | | |
| PHYSICIAN: MEDICAL | DIABETES MELLITUS 1 YES 2 NO | | | | | COMPI | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| Ä | | | | | | OF DE | ATN? | NO. | | | |
| ž | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | |
| SIA | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| Sic | | HOSPITAL: 1 ☐ Inpatient 2 X ER/Outp | etlant 3 DOA | OTHER: 4 Nursing Hom | e 5 🗆 Residenca | 8 🗆 Other | Specify) | | | | |
| H | 27. MANNER OF DEATH | (Month Day Year) | | 28b. TIME OF 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| B | 1 Natural 5 Pending 2 Accident Investigation | | M | | M 1 YES 2 NO | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, stree building, etc. (Specify) | | | street, lactory, offic | et, lactory, office 281. LOCATION (S City or Town, | | | treet end Number or Rural Route Number, State) | | | |
| ETED | 4 Nonicipe desiraned | | | | | | | | | | |
| COMPL | 29a, CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| Ö | One) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner ee stated. | | | | | | | stated. | | | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| TO B | Dorothy (Howarth M.S. | | | | DO6241 . | | | 1 8-1 | 8-16-95 | | |
| - | 30. NAME AND ADDRESS OF PERSON WILL COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BIROTHY C. HOLZINGRITH 203 SNOW ST., SNOW HILL, MD., 21863 | | | | | | | | | | |
| | | | | 03 SNR | W ST. | SNE | ow H. | LL, M | 12, - | 2186 | 3 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | | | | | | | | | |
| - 1 | AUG 21 1995 Vilis Attivition Real 1 | | | | | | | | | | |



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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENE |
|----------------------------------------------|----------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 | FOR STATE REGISTRAR | STATE OF MAR | | | HEALTH AND F DEATH | MENTAL HYGIEN | | |
|--------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------|
| | 4 | 1. DECEDENT'S NAME (First, Middle, Last | 0 | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | L | | John Fran | klin Jonas | 3 | | August 21 | , 1995 | 9:07 pm |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. last birthday) | IF UNDER 1 YEAR | | 7. DATE OF BIRTH (Month, Day, Year) | 8.8 | MRTHPLACE (State or Foreign country) |
| 3 should | 1 - | 243-12-0617 De. FACILITY NAME (If not institution, give | 1 M 2 F | 78 YRS. | 9b. CITY, TOW | HOURS MIN. | June 19, | | orth Carolina |
| 1. 2. 3 sl | 5 | 14921 Ber | ryville Road | d | | Darnesto | wn | M | lontgomery |
| Pages IRE | THE PERSON NAMED IN | Maryland 10b. COUN | | 10c. CIT | TY, TOWN OR LOC | | | | 10d. INSIDE CITY LIMITS? |
| physician. burlat-transit permit. | - 15- | 10e. STREET AND NUMBER | Montgomery | | | Darnes | COWII | 10g. CITIZEN | 1 ☐ YES 2 😿 NO OF WHAT COUNTRY? |
| ransir | <u>i</u> | | Berryville | | | 208 | | | ted States |
| D the E | 5 | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 V Y IF YES, GIVE WAR OF WORLD | er in u.s. armed es 2 do r dates War II | If yes, | | NIC ORIGIN? (Specify Yesn, Puerto Ricen, etc.) fy: | | RACE — American Indian, Black, White, etc. Specify: White |
| or use as | | 15. DECEDENT'S ED (Specify only highest grad | de completed) | 16e. DECEDENT'S (Give kind of life, Do NOT u | work done during i | TION most of working | 16b, KIND OF BU | SINESS/INDUST | RY |
| the hospital of detached for a detached for a detached for a complete COMPLE | | Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | _ | esthesic | ologist | | Medic | al |
| detach | 3 1 | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S N | AME (First, Middle, Maiden | Sumame) | |
| ed by | | | n Franklin | | | | | Crawfor | |
| retained by the hospit 5 should be detached notified at once. TO BE COMPI | | 19e. INFORMANT'S NAME (Type/Print) | 1 ~ | | | | Route Number, City or Tov | | |
| be n | - | Mary Garlan 200. METHOD OF DISPOSITION | | | | | | | yland 20874 |
| e 6 ma ector, p | | 1 Buriel 2 X Cremation 3 Rei | moval from State | 20b. PLACE AND DATE cemetery, cremetory or o | other placel At | igust 23. | 1995 | CATION — City | |
| Page Il dire | - 11- | 21. SIGNATURE OF FUNERAL SERVICE L | LICENSEE | Montgomer | 22 NAME | AND ADDRESS OF F | ic. Be | tnesda, | Maryland |
| ter death, Page 6 may be the funeral director, page syad. | | Dem D | Kerelyt | M00335 | Robe Beth Aver | ert A. Pur nesda-Che nue Bethe | mphrey Fun vy Chase, sda, Maryl | eral Ho Inc. 75 and 208 | me/ 57 Wisconsin 14-3501 |
| d in by the or removal. | | 23. PART I. Enter the diseases, or ahock, or heart fellure | complications that cause of | sed the death. Do | not enter the n | node of dying, au | ch as cardiec or resp | iratory arrest, | Approximate interval Between |
| hours y filled in b filon, or rei the medi | | IMMEDIATE CAUSE (Fine) | , , , , , , , , , , , , , , , , , , , , | | | | | | Onset and Deat |
| with pletely cremati rent, ti | | disease or condition resulting in death) | a. Large Cell | L Lymphoma As a consequence of | | ght Maxil | lary Sinus | | 4 Months |
| sician and con nior to burial, traumatic er | | Sequentielly ilet conditions, | b. DUE TO (OR A | AS A CONSEQUENCE O | FD: | | | | |
| physician ne prior 1 | 1 | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | |
| ending Hygie or off | | that initiated events resulting in death) LAST | d | AS A CONSEQUENCE O | NF): | | | | |
| - 28 B | 19 | PART II. Other aignificant condition | one contributing to deet | h but not regulting | in the underly | ing cause given in | Part I. 24e. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| any I | r III | | | | | | PERFO | RMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| n. of Heat shows | | DID TOBACCO USE | CONTRIBUTE TO | CALISE OF | DEATH | VEC CO NIC | | | 1 YES 2 NO |
| Per Per | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | CAUSE OF | | PLACE OF DEATH (C | neck only one) | | |
| the State , or Item HYSICI | , | 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/0 | Outpatient 3 DOA | OTHER: 4 - Nursing He | ome 5 X Residence | 6 Other (Specify) | | |
| T S | | 7. MANNER OF DEATH 1 X Natural 5 Pending | 28e. DATE OF INJUI (Month, Day, Yea | RY 26b. TIN | JURY Y | NJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCURE | ED |
| < in : | | | | | | | 1 | | |
| 0 10 | | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26e, PLACE OF INJI | URY — At home, farm, Specify) | street, fectory, of | fice | 261. LOCATION (Street City or Town, Stete | | ural Route Number, |
| 2 hours after do If item 28 is | | 2 Accident 3 Suicide 4 Homicide Could not be determined See CERTIFIER Check only CERTIFYING PHY | 28e. PLACE OF INJI building, etc. (S SICIAN: To the best of my ki | Specify) | red at the time, de | ite end place, end du | City or Town, Stete | nner as stated, | |
| 2 hours after do if item 28 is APLETED | 2 | 2 Accident 3 Sulcide 4 Homicide 6 Could not be determined 1 CERTIFIER (Check only one) 2 MEDICAL EXAMIN | 26e. PLACE OF INJI building, etc. (3 SICIAN: To the best of my ku NER: On the best of examin | Specify) | red at the time, de | ite end place, end du | City or Town, Stete | nner as stated, | ural Route Number, |
| IPORTANT: If item 28 is BE COMPLETED | 2 | 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 99. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | SICIAN: To the best of my ki | specify) nowledge, death occurrent atton end/or Investigate | red at the time, do | ite end place, end du | city or Town, Stete to the cause(e) and me time, date end place, er | nner as stated, and due to the cer 29d, DATE SIG | |
| T Item 28 Is APLETED | 2 2 2 3 | 2 Accident 3 Suicide 4 Homicide 6 Could not be determined Pec. CERTIFIER (Check only one) 2 MEDICAL EXAMIN Peb. SIGNATURE AND TITLE OF CERTIFIER 00. NAME AND ADDRESS OF PERSON W | 26e. PLACE OF INJI building, etc. (3 SICIAN: To the best of my ki NER: On the best of examinating TAO COMPLETED CAUSE OF | nowledge, death occur ation end/or investigation | red at the time, de on, in my opinion | te end place, end du , death occured at the 29c. LICENSE NU D 35 | city or Town, Stete to the cause(e) and me time, dete end place, et | onner as stated, and due to the cei | use(e) and menner se stated. ENED (Month, Day, Year) ust 22, 1995 |
| THE HOSPIAL DR ATTENDI THE FUNERAL DIRECTOR: A filed within 72 hours after de IPORTANT: If item 28 is BE COMPLETED | 2 2 3 | 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 99. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | 26e. PLACE OF INJI building, etc. (3 SICIAN: To the best of my ki NER: On the best of examinating TAO COMPLETED CAUSE OF | nowledge, death occur ation end/or investigation DEATH (ITEM 27) (Type ince Phili | red at the time, de on, in my opinion | te end place, end du , death occured at the 29c. LICENSE NU D 35 | city or Town, Stete to the cause(e) and me time, dete end place, et | onner as stated, and due to the cei | use(e) and menner se stated. SNED (Month, Day, Year) ust 22, 1995 |



permit. Pages 1, 2, 3 should

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Cremation.

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DIRECTOR: After this certificate has been signed by the hours after death with the State Dept. of Health and Mer

FUNERAL |

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31. DATE FILED (Month, Day, Year)
AUG 23 1995

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| /ISION OF VITAL RECORDS, P.O. I | ATTENDING F |
| \leq | 8 |
| _ | HOSPITAL |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle Last) 3. TIME OF DEATH VEAR Helen Margret Johnson August 18, 1995 2:10 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTNPLACE (State or Forming HOURS 1 M 2 X F YRS. 470-72-8987 82 June 5, 1913 Wisconsin 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF BEATH DIRECTOR Wilson Health Care Center Gaithersburg Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg 1 K YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 201 Russell Avenue 20877 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married Il yea, specify Cuban, Maxican, Puerto Rican, atc.) 1 TES 2 X NO Specify: ВУ Specify: 3 🕅 Widowed 4 🗌 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME /First Middle Last 18. MOTNER'S NAME (First, Middle, Maiden Surname) 75 Martin Hennum Ingabord Tandberg BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Thomas Russell Johnson, M.D. 10513 Tyler Terrace, Potomac, Maryland pe 20a. METNOD OF DISPOSITION
1 ☐ Burlel 2 M Cremation 3 ☐ R 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must b DATE Crematorium, Inc. 4 Donation 6 Other (Specify) Montgomery Bethesda, Maryland 22 NAME AND ADDRESS OF FACULTY
ROBert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery
Avenue, Rockville, Maryland 20850-2805 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 awrence Darbarayo traumatic event, the medical 23. PART I. Enter the disease, or complications that caused the death. Do not saler the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease pr condition_ erebral arterio sclarosis resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Application PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TES 2 NO OF DEATN? Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔀 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) item HOSPITAL 1 YES 2 NO 27. MANNER OF DEATH 1 Inpetient 2 ER/Outpetient 3 DOA 10 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 2 Accident 5 Pending Investigation t YES 2 NO BY 28s. PLACE OF INJURY — At home, larm, atreet, factory, office building, etc. (Specify) 3 Suicide 80 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide item 29s. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. = TO THE HOSPITA
TO THE FUNERA
De filed within 7. 2 MEDICAL EXAMINER: On the besis of a nination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated, 294: SIGNATURE AND THILE OF CHROTFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 7231 August 18,1995

Mz

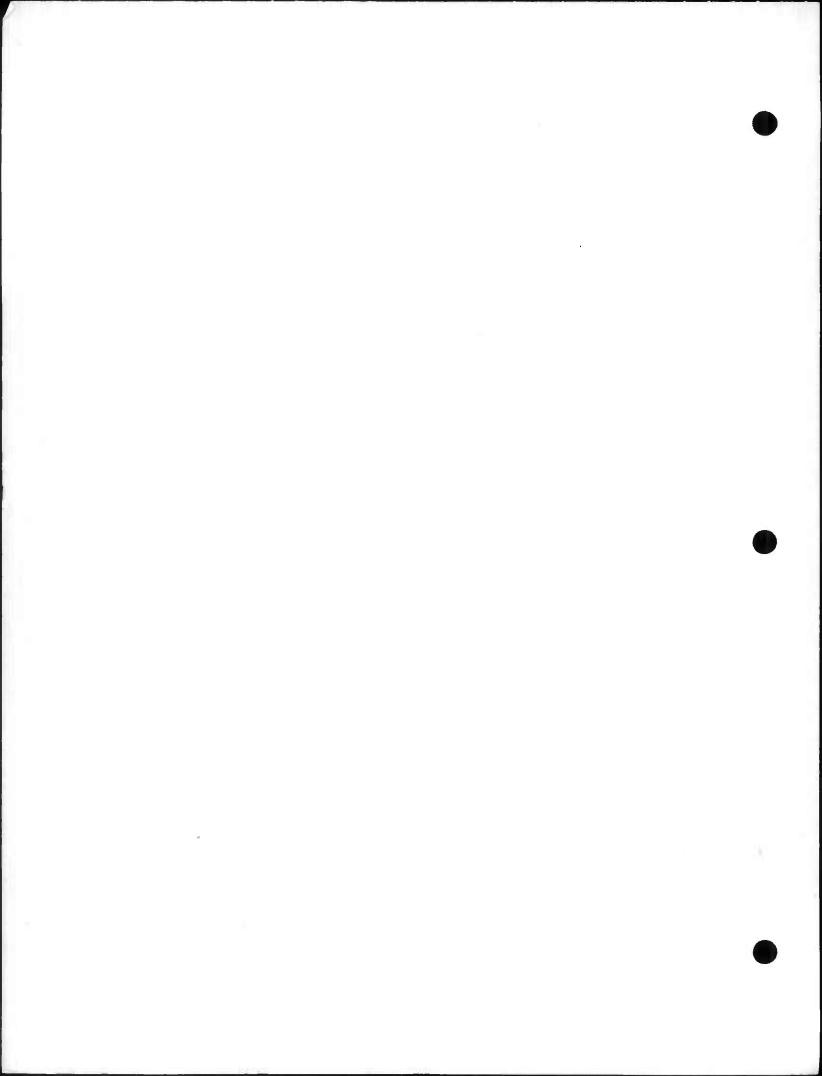
Ave

Gaithersburg

COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

207 Brodues
32. REGISTRAR'S SIGNATURE

Julia Marchan Roubell



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and completely filled in by the funeral director, page 5 may be retained by the bunk-transit permit. Pages 1, 2, 3 should be detached for use as the bunk-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to bunkl, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month. AUG

22 1995

32 REGISTRAR'S SIGNATURE

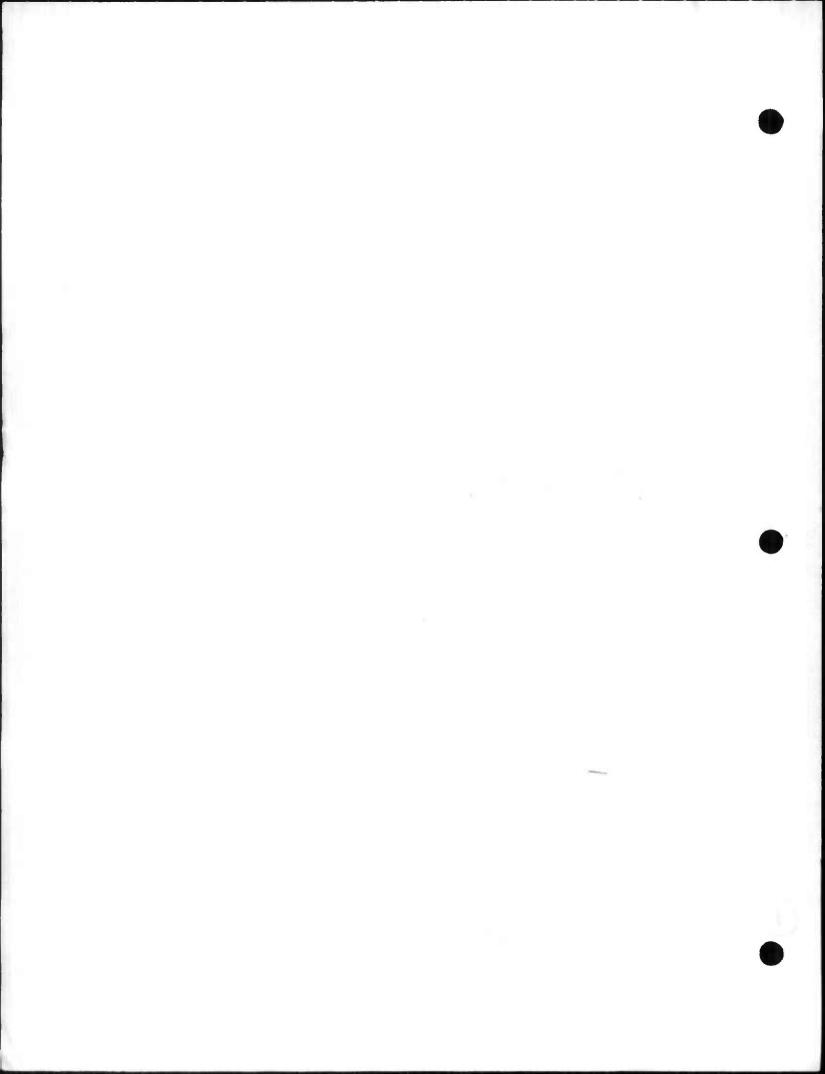
| 711 | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAND | / DEPAR | RTMENT OF | F HEALTI | H AND | MENTAL HYGIEN | E | <i>-</i> | , , , , |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------|------------------------|----------------------------------|-----------------------|------------|-----------------------------------------------------|--------------|------------------------------|---------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Las | 5/120 po | | lan | us | | | DATE OF DEATH MONTH | 7,199 | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 150-16-6999 | 5. SEX | 6. AGE (In yrs. 80 | last birthday) YRS. | IF UNDER 1 YE | - | MIN. | Month, Day, Year) Dec. 31,1 | 914 | B. BIRTHE Country, New | LACE (State or Foreign |
| - | 9e. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOV | VN OR LOCA | TION OF DI | | | INTY OF DE | |
| DIRECTOR | 7907 Indian Head | l Highway | | | 0xon | Hill | | | Pri | nce G | eorges |
| 3EC | 10a. STATE 10b. COUN | ТҮ | | 10c, CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| | Maryland Prin | ce Georges | 5 | 0x | on Hil | l | | | | | LIMITS? |
| 3AL | 10e. STREET AND NUMBER | | | | | 10f. ZIP CO | | | | | HAT COUNTRY? |
| FUNERAL | 7907 Indian Head | | | | | 207 | | | | | States |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | | YES 2 | ARMED NO | If you | , specify Cut | en, Mexice | NIC DRIGIN? (Specify Yearn, Puerto Ricen, atc.) | or No- | 14. RACE Black, | - American Indian, White, etc. |
| ВУ | 3 📉 Widowed 4 🗌 Divorced | IF YES, GIVE V | AR OR DATES | | 10 | YES 24 NO |) Specify | у. | | Specify | Black |
| LED | 15. DECEDENT'S ED (Specify only highest gra | | 180. | DECEDENT'S | USUAL OCCUP | ATION most of word | dna | 16b. KINO OF BU | SINESS/IN | DUSTRY | |
| ĽE | Elementary/Secondary (0-12) | College (1-4 or 5 | , | | work done during se retired.) | , | | | _ | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | Nurse | | 48.40 | ******** | Hospi | | | |
| Ö | Ellis Morton | | | | | | | e McDaniel | Sumame) | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | | 19b, MAILING | ADDRESS (Str | | | Route Number, City or Tow | n, Stete, Zi | p Code) | |
| 2 | Linda Okusaga | | | 13414 | Kris I | Ran Co | urt, | Ft. Washi | ngto | n, Md | . 20744 |
| | 20a METHOD OF DISPOSITION 1 (X Burlet 2 Cremetion 3 Re 4 Donation 5/ Other (Specify) | moval from State | 20h PLAC | E AND DATE | OF OISPOSITION | (Name of | | | CATION | City or Tow | n State |
| | 21. SIGNATURE OF FUNERAL SERVICE | ICENSED | 2 | 20122 | 22. NAM | E AND ADDR | ESS OF FA | CILITY | | | VIIgIIIIa |
| | XX 00 111 | | m | z | | | | al Service Ave. N.W., | - | | D C |
| | 26. PART I. Enter the diseases, or shock, or heart fellure iMMEDIATE CAUSE (Finel disease or condition resulting in dasth) | the tenen | t couced the dise on each line. (DR AS A CONS | ne. | WAS CL | mode of d | ying, suc | h es cerdiec or respi | ratory sr | rest, | Approximats Interval Batween Onast and Desth |
| CERTIFICATION | Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c, | (DR AS A CONS | | | | | | | | |
| ا ہے | PART In Other significant condition | | | | | ying ceuse | given in | Part i. 24a. WAS AN PERFOR | MEO? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Σ | DID TOBACCO USE CON | RIBUTE TO CA | LISE OF DE | ATH YE | S \square NO | D UN | CERTAIN | | | | YES 2 NO |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 26. PL | ACE DF OEA | OTHER: | ine) | | | | | |
| | 27. MANNER OF OEATH 1 Netural 5 Pending | 1 Inpatient 2 I | INJURY | 28b. TIM | E OF 28c. | INJURY AT WORK? | | 6 Other (Specify) 26d. DESCRIBE HOW II | NJURY OC | CURED | |
| ED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE O building, | F INJURY — At I | home, term, | | YES 2 | ND ND | 28f. LOCATION (Street e City or Town, State) | and Number | r or Rural Ro | ute Number, |
| COMPLETED | | | | | | | | to the cause(a) end mar time, date end piece, en | | | end menner ee stated. |
| B | 29b. SIGNATURE AND TITLE OF SHITE | shifting. | an | | | 1 | 200 1230 | HDE/H | 294/DAT | E SIGNED O | Moren, Day, Wars |
| 2 | 30. NAME AND ADDRESS OF PLASON W AUGUSTO P. ROCK | V | | | | Cam | n Snr | cinas MD 1 | 20745 |) | 7 |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

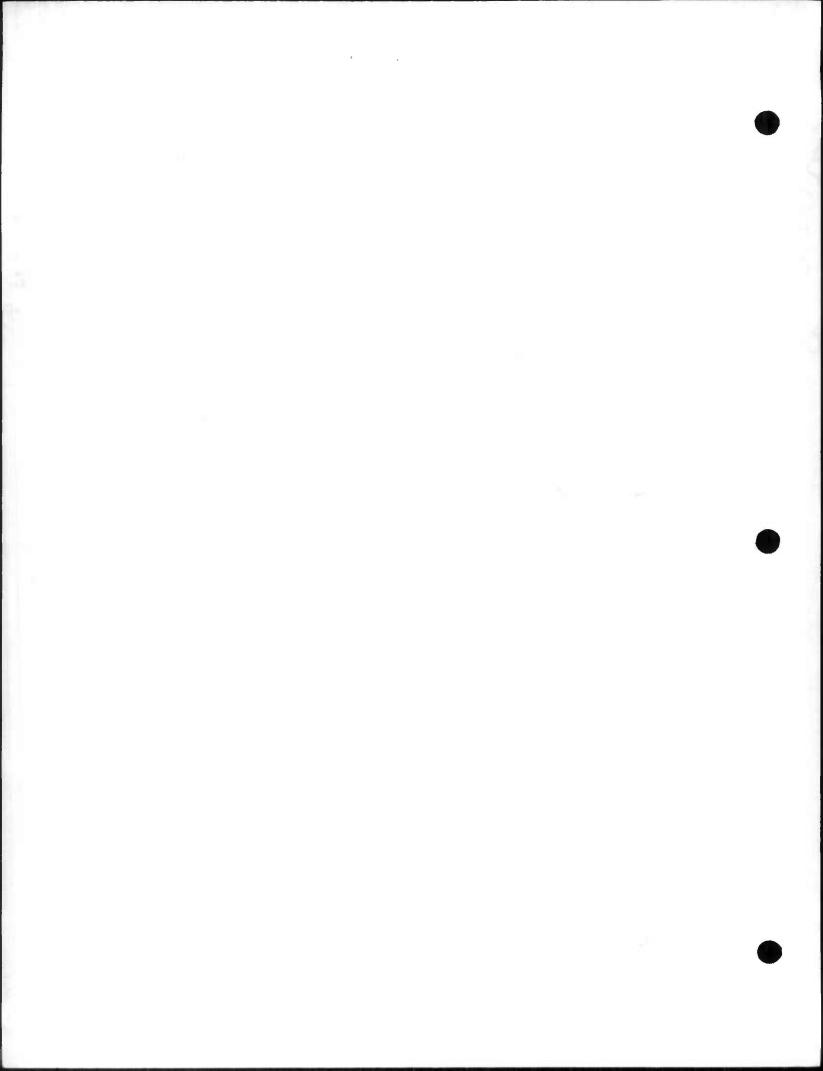
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| | 1. DECEDENT'S NAME (First, Middle, Last NGABANG | • | ACAID. | ** | | | | 2. DATE OF MONTH | DAY | YEA | |
| | 4. SOCIAL SECURITY NUMBER | RAYN 5. SEX | | | ALONJ | - | | AUGU | | 199 | |
| | 577-92-3058 | 1 M 2 F | 6. AGE (In yrs | i. lest birthday) 7 YRS. | MONTHS (| _ | HOURS MIN. | 7. DATE OF I | ly, Year) | 0 | ountry) Zaire |
| | 9a. FACILITY NAME (If not institution, giv | | 5 | THS. | | | | | 3/38 | | ınshasa |
| œ | 7705 Eastern | | | | l . | | LOCATION OF DE | | | COUNTY | |
| DIRECTOR | RESIDENCE OF DECEDENT | Avenue | | | 511 | ver | Sprin | g | M | ont | gomery |
| Ä | 10a. STATE 10b. COU | NTY | | 10c. CIT | Y, TOWN OR | LOCATIO | ON | | | | 10d. INSIDE CITY |
| ā | Maryland Mon | tgomery | | S | ilver | Sp | ring | | | | LIMITS? |
| A. | 10s. STREET AND NUMBER | | | | | | ZIP CODE | | 109 | . CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | 7705 Eastern | Avenue | | | | 2 | 0912 | | | Za | aire |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. WA | S DECEN | DENT OF NISPAN | IC ORIGIN? (S | pecify Yes or No | 14. F | BACE - American Indian |
| B | 1 Never Married 2 Married 3 Wildowed 4 Divorced | | MAR OR DATES | | | | Ify Cuben, Mexican | | n, etc.) | | Black, White, etc. Specify: Black |
| | 15. DECEDENT'S El (Specify only highest gra | DUCATION ade completed) | 18a. | DECEDENT'S | USUAL OCC | UPATION | of working | 16b. KIN | D OF BUSINES | S/INDUSTF | TY |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Iffe. Do NOT u | se retired.) | my most e | or working | | | | |
| COMPLET | 10th | | | Un | emplo | oye | d | 1 | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | 2 | | | | | 18. MOTNER'S NAI | | | me) | 100 |
| BE | Buanga Lik | 7 | | | | | Ana | Sawa | | | |
| ٥ | 19a. INFORMANT'S NAME (Type/Print) Wiza Mafut | 2 | | | | | Number or Rural R | | | | 2000 |
| | Wiza Mafut | a | | | | | | | ., Si | lver | Spring, |
| | 12 Buriel 2 Cremation 3 Re | emoval from State | 20b. PLA carnetery. | CEAND DATE | OF DISPOSITI | ON (Name | e of | DATE | 20c. LOCATIO | N — City o | or Town, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | _ Har | mony | Memo. | rıa | 1 Park | 8/17/ | 95 La: | ndov | er, MD. |
| 3 | | 120 | 1 | | A | ust. | address of FAC | ster | Funer | al H | lome |
| | - ann | 17/1 | | | | | | | | | |
| | 23. PART I. Enter the disease, o shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) | e. List only one cat | t caused the use on each in CLEROTIC | line. | not enter th | 605 na moda | 14th | St. N | . W . , W | ash, | Interval Bet |
| TIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | a. ATHEROS DUE TO DUE TO C. | ise on each i | C CARDIO | VASCUL | 605 na moda | 14th | St. N | . W . , W | ash, | Approximate Interval Bet |
| MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. ATHEROS DUE TO b. DUE TO c. DUE TO d. lone contributing to | CLEROTIC (OR AS A CON (OR AS A CON (OR AS A CON death but no | C CARDIC RECUENCE OF THE PROPERTY OF THE PROP | DVASCUL | 605 na moda AR DI | 14th a of dying, such | Part I, 24s | . W , W. or reapiratory | y arreat, | Approximate Interval Bett Onset and E Onset E |
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| ED BY PHYSICIAN: MEDICAL | SHOCK, Of hyant tailor IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditi DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 \(\triangle \ | a. ATHEROS DUE TO b. DUE TO c. DUE TO d. ITRIBUTE TO CA HOSPITAL: 1 Inpatient 2 (Month, D) 28a. PLACE O | CCLEROTIC (OR AS A CON (OR AS A CON death but no | EATH YE LACE OF DEAT 13 DOA 28b. TIM | DVASCUL F): F): In the under IN (Check only OTHER: 4 Nursing E OF URY M | AR DI AR DI y one) g Nome c. INJUR WORK 1 YES | 14th a of dying, such ISEASE Ceuse given in I | Part I. 24s 1 1 24s 3 Other (Sp 28d, DESCRIII | . WAS AN AUTOI PERFORMED? YES 2 No | y arreat, | Approximate Interval Bett Onset and E Onse |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other aignificant conditions are sufficient conditions. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural STPENDING Investigation determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHY | a. ATHEROS DUE TO b. DUE TO c. DUE TO d | CCLEROTIC (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A | EATH YE LACE OF DEAT 28b. TIM INJ thome, ferm, indicates of the courts | DVASCUL F): F): In the under S NC N (Check only OTHER: 4 Nursing E OF URY M Intreet, factory | AR DI arriving c y one) g Nome lic. INJURK 1 UPES r, office | 14th a of dying, such ISEASE UNCERTAIN TY AT 17 12 NO | Part I. 24a 1 [] 3 Other (Sp 28d. DESCRIE | WAS AN AUTOO PERFORMED? YES 2 No ec/fy) SE HOW INJURY N (Street and Num, State) | OCCURED mber or Ru | Approximate Interval Bets Onset and E Onse |
| ED BY PHYSICIAN: MEDICAL | SHOCK, Or hyant tailor IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificant conditi DID TOBACCO USE CON 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 2 Accident 3 Suicide 6 Could not b determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | a. ATHEROS DUE TO b. DUE TO c. DUE TO d. ITRIBUTE TO CA HOSPITAL: 1 Inpatient 2 28e. DATE OF (Month, D) 28e. PLACE Of building. | CCLEROTIC (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A | EATH YE LACE OF DEAT 28b. TIM INJ thome, ferm, indicates of the courts | DVASCUL F): F): In the under S NC N (Check only OTHER: 4 Nursing E OF URY M Intreet, factory | AR DI arriving c y one) g Nome lic. INJURK 1 UPES r, office | 14th a of dying, such ISEASE UNCERTAIN TY AT 17 12 NO | Part I. 24a 1 [] 3 Other (Sp 28d. DESCRIE | WAS AN AUTOO PERFORMED? YES 2 No ec/fy) SE HOW INJURY N (Street and Num, State) | OCCURED mber or Ru | Approximate Interval Bets Onset and E Onse |
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| TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | SHOCK, Or hyant tailor IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificant conditi DID TOBACCO USE CON 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 2 Accident 3 Suicide 6 Could not b determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | a. ATHEROS DUE TO b. DUE TO c. DUE TO d. ITRIBUTE TO CA HOSPITAL: 1 Inpatient 2 28e. DATE OF (Month, D) 28e. PLACE O building. | CCLEROTIC (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON (OR AS A CON INJURY Last (Specify) The state of the sta | EATH YE LACE OF DEAT I home, ferm, in , death occurrently into the series of the seri | In the under the | AR DI arriying c y one) g Nome ic. INJUR WORK 1 YES r, office | 14th a of dying, such ISEASE UNCERTAIN TO AT (2) TO AT (2) The place, and due to the occurred at the income at | Part I. 24e 1 [] 3 Other (Sp 28d. DESCRIII 28f. LOCATIO City or To to the cause(a time, data and BER | . WAS AN AUTOI PERFORMED? YES 2 No. No. (Street and Numer, State) and menner as place, and dua | PSY OCCURET | Approximate Interval Bets Onset and E Onset E |



nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | I, 2, 3 shoul |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARY | | MENT OF H | | MENTAL HYGIEN | | |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------|----------------------------------------------------------|------------------------------------------------------------|---------------------|-------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Less THOMAS | DERING | Ki | ng | | 2. DATE OF OBATH AUGUST 8 | == | 3. TIME OF DEATN 10:10A |
| | 4. SOCIAL SECURITY NUMBER 575-01-6648 | 5. SEX 6. AGE | (in yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) OCT • 6 , 19 | 12 HZ | THPLACE (State or Foreign nitry) |
| DIRECTOR | 9a. FACILITY NAME (If not institution, give MEMORIAL HOSP RESIDENCE OF DECEMENT | | | | TON | EATN | 9c. COUNTY OF TALBO | |
| EG C | 10a, STATE 10b. COU | ITY | 10c. CITY | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| - 1 | MARYLAND 10s. STREET AND NUMBER | TALBOT | | NEAV: | ZIP CODE | | 40- 0171779 01 | LIMITS? 1 VES 2 NO WHAT COUNTRY? |
| FUNERAL | 6369 THAMERT | ROAD | | 100 | 21652 | | US | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 XXES IF YES, GIVE WAR OR E | 2 NO | If yes, sp | ENDENT OF HISPAL ecity Cuban, Mexico 2X NO Specifi | NIC ORIGIN? (Specify Yea an, Puerto Rican, atc.) ly: | Bia | CE — American Indian, ick, White, atc. WHITE |
| COMPLETED | 1s. DECEDENT'S El (Specify only highest gra Elementary/Secondary (0-12) | OUCATION de completed) College (1-4 or 5 +) | 16a. DECEDENT'S L (Give kind of w life. Do NOT use | ork done during mo | DN at of working | 16b. KIND OF BUS | INESS/INDUSTRY | |
| MP | 12 | 4 | DISTRI | BUTOR | | OIL | INDUSTE | RY |
| | 17. FATNER'S NAME (First, Middle, Last) | RING | | | | ME (First, Middle, Maiden : | | |
| H | THOMAS VICTOR 19a. INFORMANT'S NAME (Type/Print) | KING | 19b. MAILING | ADDRESS (Street o | | SABEL NEV | | |
| 임 | BENNETT CRAIN | | | | | APOLIS, N | |)3 |
| | 20a. METHOD OF DISPOSITION 1 Burlat 2 X Cremation 3 Re | moval from State 200 | . PLACE AND DATE O | FDISPOSITION /No | me of | DATE 20c. LOC | CATION — City or | Yown, State |
| | 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE | | ALISBUR | | ATORY D ADDRESS OF FA | | SBURY, | MARYLAND |
| | B. Keith | Physpm | , CFSP | NEWN | AM FUNE | RAL HOME | | OM _ MO |
| RTIFICATION | 23. PART I. Enter the diseases, or ahook, or heart feilur immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. RESP. DUE TO (OR AS DUE TO (OR AS C. | d the death. Do not be the line. A CONSEQUENCE OF A CONSEQUENCE OF | FA | 1 L U Z-E | | ratory arrest, | Approximate Interval Between Onset and Death 3 3 A44 |
| S | PART II. Other algoriticent conditions | d. | out not resulting in | the underlylor | r cause glyen in | Part 1. 24s. WAS AN | Alimney La | Ib. WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | PERFORI | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | DID TOBACCO USE CON | TRIBUTE TO CAUSE C | | | UNCERTAI | N D | | |
| SICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | HOSPITAL: | | OTHER: | • • • • • • • • • • • • • • • • • • • • | | | |
| Y PHYSICIAN: | 27. MANNER OF DEATH 1. Netural 5 Pending 2 Recident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c, INJ | JRY AT | 6 Other (Specify) 28d. DESCRIBE HOW IN | IJURY OCCURED | |
| TED B | 3 Suicide 6 Could not b 4 Homicide determined | 26a. PLACE OF INJURY building, etc. (Spe | — At home, farm, at city) | reat, factory, office | | 26f. LOCATION (Street at City or Town, State) | nd Number or Rura | Floute Number, |
| COMPLETED | | SICIAN: To the best of my know NER: On the bests of examination | | | | | | (s) and menner sa stated. |
| IO BE | 296. SIGNATURE AND TITLE OF CERTIF | 8 Can Co | | | De / | 2Z5 | 29d. DATE SIGNE | (Month, Day, Year) |
| | | RNEY, M.D., | 509 II | | AVENU | E, EASTON | I, MD | |
| | AUG 1 1 1995 | 02. REGISTRAR'S SIGN | hardall | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------|--------------------------|-------------------------|-----------------------------------------------------|-----------------|-------------------------------------------------------------------------------------|
| | | Jody Bet | h Koer | ig | | August ' | 20 19 | 95 11:15p. M |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR | Oldneth One March | | 8. BIRTHPLACE (State or Foreign Country) |
| | 577-82-3013 | 1 □ M 2XX F 35 | YRS. | MONTHS DAYS | HOURE MIN | 8/12/60 | | Washington, D.C |
| ~ | Sa. FACILITY NAME (If not institution, give at | reet and number) | | 9b. CITY, TOW | OR LOCATION OF | DEATH | | TY OF DEATH |
| CTOR | 2806 Ocala Ave. | | | Forest | ville | | Prin | ce George |
| l iii | 10a. STATE 10b. COUNTY | | 10c. CI1 | Y, TOWN OR LOC | ATION | | | 10d, INSIDE CITY |
| DIRE | Maryland Prince | George | For | estvill | 2 | | | LIMITS? |
| A P | 10e. STREET AND NUMBER | | 1-02 | | Of. ZIP CODE | | 10g. CITIZ | EN OF WHAT COUNTRY? |
| FUNERAL | 2806 Ocala Ave. | | | | 20747 | | USA | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS D | CENDENT OF HIS | PANIC ORIGIN? (Specify Yelloan, Puerto Rican, etc.) | e or No- | 14. RACE — American Indian, Black, White, etc. |
| ₽ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATESTA | | S 2 X NO Sp | | , | Specify: White |
| 8 | 15, DECEDENT'S EDUC | | 18a. DECEDENT'S | USUAL OCCUPA | ION | 16b. KIND OF BU | | |
| | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT u | | | | | |
| once. | 12th | | Member | Service | s Uffice | r Bankin | g | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S | NAME (First, Middle, Maiden | Sumame) | |
| B a | James F. King | | | | | M. Pyles | | |
| 10 | The state of the s | | | | | rel Route Number, City or Tox | n, State, Zip (| Code) |
| 9 | Michael A. Koenig | 720 | Same b. PLACE AND DATE | as ite | | 2000 | 0.171011 0 | |
| Tane. | 1 N Burial 2 Cremation 3 Remo | val from Stata | metery, cremetory or cedar Hil. | ther piece) | erv 8/2 | | | Md. 20746 |
| ner | 21. SIGNATURE OF FUNERAL SERVICE LICE | ENSILE | oddi iii. | 22. NAME | AND ADDRESS OF | FACILITY | | 11d: 20140 |
| шех | *Since K | also his | | | | as Funeral | | |
| 100 | 23. PART I. Enter the diseases, or 6 | omplications that cause | d the death. Do | 010U | Uxon Hi | 11 Rd. Oxon | Hill | Md . 20745 |
| vent, the me | shock, or heart failure. L IMMEDIATE CAUSE (Finel disease or condition resulting in death) | _Multiple | each line. | sis | | | | Interval Between Onset and Death |
| ry, or other traumatic event, the medical examiner must be notified at CERTIFICATION TO BE C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | A CONSEQUENCE O | | | | | |
| 29 | PART II. Other algnificant conditions | contributing to death i | out not resulting | In the underly | na cause alven | In Part I. 24s, WAS AN | ALITORAL | 241 WERE AUTOROV ENGINEE |
| ows any injury, MEDICAL CI | Epilepsy, bedr | | | | ng cause given | PERFOI | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ā | DID TOBACCO USE CONTR | IBUTE TO CAUSE O | OF DEATH YI | S I NO | UNCERTA | UN 🗆 | | 1 TES 2 NO |
| - | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | |) | | | |
| PHYSICI | 1 TYES 2 NO | 1 Inpetient 2 ER/Out | patient 3 🗆 DOA | OTHER: 4 - Nursing Ho | me 5 Haaldend | 8 Other (Specify) | | |
| marked, BY PH | 27. MANNER OF DEATH 1/2 Natural 5 Pending 2 Accident Investigation | 28a, DATE OF INJURY (Month, Day, Year) | 28b. TIM | IURY Y | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW I | NJURY OCCU | RED |
| 28 is TED | 3 Suicide 8 Could not be detarmined | 28s. PLACE OF INJURY building, atc. (Spe | Y — At home, ferm, cify) | street, factory, of | ce | 281. LOCATION (Street City or Town, State) | and Number o | r Rural Route Number, |
| 를 를 | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER | IAN: To the best of my know | riedge, death occurr on and/or investigation | ed at the time, de | a and place, and d | ue to the ceuse(a) and man | nner as stated | i. cause(a) and manner as stated. |
| BE | THE SIGNATURE AND TITLE OF CERTIFIER | Rodrege | ~M) | | 29c. LICENSE N D2123 | | | signed (Month, Day, Year) |
| 2 | 30. NAME AND DDRESS OF PERSON WAS Augusto P. Rodrigu | COMPLETED CAUSE OF DE 102, M.D. 50 | 09 Raybu | rn Ct., | Camp Sp | orings, MD 2 | | |
| 7 | 31. DATE FILED (Month, Day, Year) AUG 28 1995 | 32, REGISTRAR'S SIGN | IATURE | | | | | |
| | 1 | | | | | | | DHMH-16 Rev 1/89 |

| | ricalotrian | | CENTIF | CATE | JE DEATH | REG. NO |). | |
|---------------|--------------------------------------------------------------|----------------------------------------------------|---------------------|--------------------------------|------------------------------------|-------------------------------------------------|-------------------|-------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) DONALD J. KULI | CK- Donald | TIF | D. W. | ilick | | DAY Y | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | yrs. lest birthday) | IF UNDER 1 YE | 7. 11 - | AUGUST | 21, 19 | |
| | | | | | AR IF UNDER 24 HRS. YS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreig Country) |
| | 151-32-4897 Se. FACILITY NAME (If not institution, give st | AS 31 | Z 1110. | OL OUTY TO | WN OR LOCATION OF D | Jan. 26, 194 | | lew Jersey |
| OR | | S HOPKINS HOS | PITAL | | TIMORE CIT | | 9c. COUNTY | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | | | | | | |
| DIRECTOR | | | 10c. CIT | Y, TOWN OR L | | | | 10d. INSIDE CITY LIMITS? |
| ם ו | Maryland Mon | ntgomery | | Silve | r Spring | | _ | 1 TYES 2 NO |
| RA | | D 1 | | | 10f. ZIP CODE | | 1.75 | N OF WHAT COUNTRY? |
| FUNERAL | 12913 Holdridge | KOAG 12. WAS DECEDENT EVER IN U | O ADMED | 1 40 11110 | 2090 | | U.S.A | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes | s, specify Cuban, Maxico | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | 8 or No- 14 | . RACE — American Indian, Black, White, atc. |
| ΒY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATE | :8 | 10 | YES 2 NO Specif | fy: | T. | Specify: Thite |
| ETED | 15. DECEDENT'S EDUC (Specify only highest grade | | e. DECEDENT'S | USUAL OCCU | PATION | 16b. KIND OF BU | | |
| ᄪ | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | vork done durin e retired.) | g most of working | | | |
| COMPL | | 5+ Pt | ublic A | dminis | trator | Federal | Gover | nment |
| ဂ္ဂ ဂ | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTNER'S NA | AME (First, Middle, Maider | Surname) | |
| BE | John A. Kulick | | | | Helen | E. Kovacs | | |
| 6 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (St | reet and Number or Rural | Route Number, City or Tox | vn, State, Zip Co | ode) |
| | Christine D. Kuli | ck | 12913 1 | Holdri | dge Road | Silver Spr | ing,Ma | ryland 2090 |
| | 20e. METHOD OF DISPOSITION 1 [XBuriel 2] Cremetion 3 [XRemo | oval from State 20b.Pt | LACE AND DATE O | Phar place) | N (Name of | OATE 20c. LC | OCATION — City | y or Town, State |
| Į, | 4 Donation 5 Other (Specify) | St. | James' | Cemet | ery 8/ | 25/95 Wood | lbridge | New Jersey |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | Fran | CIS J. COl | lins Funer | al Hom | ne. Inc. |
| - 10 | Limothy | dy (Gant | Min | | | | | or.,MD 20901 |
| CERTIFICATION | Sequentially list conditions, | OUE TO (OR AS A CO | TRANS ONSEQUENCE OF | PUNTE CLE | D LIVEZ | | ILU ZE | 2 WEE 3 WEE 2 YEAR |
| | PART ii. Other algnificant conditions | a contributing to death but | not resulting i | n the under | lving cause given in | Part i. 24s. WAS AN | AITTOREY | 24b. WERE AUTOPSY FINDI |
| EDICAL | RENAL FAI | | | | lying cause given in | PERFO | RMED? | AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? |
| ME | 8 | | | | | _ ' | | 1 TES 2 NO |
| ÿ | DID TOBACCO USE CONTR | | | | | N 🗆 | | /~ |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | PLACE OF DEAT | N (Check only oTHER: | one) | | | |
| YS. | 1 TES 2 NO | 1 Conpetient 2 ER/Outpetie | | 4 - Nursing | Nome 8 🗆 Residence | 8 Cher (Specify) | | |
| | 27. MANNER OF DEATN 1 Natural 5 Pending | (Month, Day, Year) | 286. TIME | URY | INJURY AT WORK? | 28d. DEŞCRIBE HOW | INJURY OCCUR | RED |
| B | 2 Accident Investigation | AND THE ACT OF HER HIDE | | | YES 2 NO | | | |
| | 3 Suicide 8 Could not be determined | 28a. PLACE OF INJURY — building, atc. (Specify) | At nome, term, a | treet, factory, | offica | 281. LOCATION (Street City or Town, State) | and Number or i | Rurel Route Number, |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my knowledge | ge, death occurre | d at the time, | date and place, and due | to the cause(s) and ma | nner as stated. | |
| S | | R: On the beals of axamination as | | | | | | suse(a) and manner as state |
| Ö | 296. SIGNATURE AND THE OF GERTIFIER | | | | 29c. LICENSE NUI | | | IGNED (Month, Day, Year) |
| 0 | 156 (10) | SURGICAL | INTER | 7 | | 1281 | | UST 22, 199 |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE OF DEATH | I (ITEM 27) (Type, | Print) | - | | 71001 | × 20 140 |
| ł | RICH WALTER | , JOHNS | HOPK | | HOSFITA | C, RKITI | MURL | 8SIS CIM, |
| | 31. DATE FILEO (Month, Day, Year) | 2 32. REGISTRAR'S SIGNATI | IRE | | | 7 | | |
| | AUG 24 1995 9 | who Davelson Rand | all | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

J. BERGER MD 31. DATE FILED (MONTH), Day, Year) AUG 25 1995

| HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with each overs after death. Page 6 may be retained by the hospital or attending physician. | FENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans | ï | |
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| | REGISTRAR | | | MARYLAN | CERTIE | ICATE OF | POFATH | REG | NO | | |
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| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | 2. DATE OF DEA | | | 3. TIME OF DEA |
| 1 | GERTI | CILIS | F | Α. | 2.1 | PSCO | MB | AUGUST | DAY 21 | 1995 | 1:00 |
| | 4. SOCIAL SECURITY NUMB | - | 5. SEX | | yrs. last birthday) | IF UNDER 1 YEAR | _ | 7. DATE OF BIRT | - | | LACE (State or |
| ١. | 548-52-9806 | | 1 □ M 2 √ F | 68 | | MONTHS DAYS | | (Month, Day, Ye | ar) | Country |) |
| e i | 9e. FACILITY NAME (If not ins | stitution, give | 112 | 00 | 0 | Sh CITY TOWN | OR LOCATION OF | April 8 | 1927 | Beli | ze C.A. |
| 00 | | | | | | | | DEATN | | | FORGE |
| 18 | 10243 Prince | EDENT | e | | | La | rgo | | 1210 | NGE G | FOICOF |
| DIRECTOR | 10e. STATE | 10b. COUNT | Υ | | 10c. CIT | Y, TOWN OR LOC | ATION | | | | 10d. INSIDE CIT |
| 1 | Maryland | Pri | nce Georg | ges | | Large | 0 | | | 1. | LIMITS? |
| A | 10e. STREET AND NUMBER | | | | | | Of. ZIP CODE | | 10g. Cl | | AT COUNTRY? |
| FUNERAL | 10243 Prince | Plac | е | | | | 20772 | | | USA | |
| 3 | 11. MARITAL STATUS | | 12. WAS DECEDENT | T EVER IN U. | S. ARMED | 13. WAS DE | | ANIC ORIGIN? (Speci | ly Yes or No — | 1 | - American Inc |
| | 1 Never Merried 2 1 | | FORCES? 1 IF YES, GIVE W | | | If yes, a | specify Cuben, Mexic | en, Puerto Rican, et | 2.) | Black, Specify | White, etc. |
| B | 3 🔀 Widowed 4 🗌 Divor | reed | | | | | 4.0 | .,, | | Specify | Whit |
| 8 | | EDENT'S EDU | | 16 | Sa. OECEDENT'S | USUAL OCCUPAT | TION | 16b. KIND O | F BUSINESS/IN | IOUSTRY | WILL |
| E | Elementery/Secondary (0- | | College (1-4 or 5+ | -) | life. Do NOT us | work done during n se retired.) | ost or working | | | | |
| MP M | 12 | | | | Home | maker | | Own | Home | | |
| COMPL | 17. FATNER'S NAME (First, Mic | | | | | | 18. MOTNER'S N | AME (First, Middle, M | eiden Surname) | | |
| BE (| James N. M | | | | | | Madeli | ne Peeb | les | | |
| 10 | 194. INFORMANT'S NAME (7) | | | | 196. MAILING | ADDRESS (Street | end Number or Rura | Route Number, City of | r Town, State, Z | ip Code) | |
| F | Ann M. Lips | comb | | | 10243 | Prince | Place La | argo, Mar | yland | 20772 | |
| | 20e. METNOD OF DISPOSITION 1 ☐ Burlel 2 🙀 Cremetlon | | and from State | 20b. PL | ACEANDDATE | OF DISPOSITION // | | | c. LOCATION | | n, State |
| | 4 Donation 5 Other | (Specify) | TOWN STATE | Meti | ry, crematory or o | an Crem | atory 8- | 23-95 A | exandi | ria. V | irgini |
| | 21. SIGNATURE OF FUNERAL | SERVICE LI | CENSEE | | | 22. NAME | AND ADORESS OF F | ACILITY | | | |
| | 1 10 | | | | | | | | | | |
| | I Walas | 1-5 | Cus | Ω_{ij} | | | | ins Funer | | | |
| | 23 PART I From the di | t Ec | Evous: | Per | 20, | 16000 | Annapol | is Road | Bowie | Marz | land 20 |
| | 23. PART I. Enter the dia | acesea, or | EU ONO: complicationa triet Liet only one cause | caused th | ne death. Do r | 16000 | Annapol | is Road | Bowie | Marz | land 20 |
| | 23. PART I. Enter the did ahock, or he IMMEDIATE CAUSE (Final | acosea, or eart fellure. al | complications that Liet only one cause | caused the | ne death. Do r | 1600(not enter the m | Annapo] ode of dylng, su | is Road ch as cardiac or | Bowie | Marz | Approxin Interval I Onset ar |
| | 23. PART I. Enter the dia shock, or he | acosea, or eart fellure. al | complications that Liet only one cause | caused the | ne death. Do r | 1600(not enter the m | Annapo] ode of dylng, su | is Road ch as cardiac or | Bowie | Marz | Approxin Interval I Onset ar |
| | 23. PART I. Enter the dis ahock, or he IMMEDIATE CAUSE (Find disease or condition | acosea, or eart fellure. al | e. A CUTE | caused thee on each | ne death. Do n Illne. | 1600(not enter the m | Annapolode of dying, su | is Road ch as cardiac or | Bowie | Marz | Approxir Interval I |
| NOI | 23. PART I. Enter the disabock, or he IMMEDIATE CAUSE (Find disease or condition resulting in death) | neesea, or eart fellure. al | e. A CUTE | caused thee on each | ne death. Do n Illne. | 1600(not enter the m | Annapolode of dying, su | is Road ch as cardiac or | Bowie | Marz | Approxir Interval I |
| ATION | 23. PART I. Enter the disabook, or he IMMEDIATE CAUSE (Find disease or condition resulting in dasth) | neesea, or eart fellure. | e. A CUTE OUE TO (DUE TO (| t caused the ee on eech (OR AS A COUNTY (OR AS | OCAR DISSECUENCE OF | 16000 not enter the m | O Annapolicode of dying, su NEARC SEASE | is Road ch as cardiac or | Bowie | Marz | Approxir Interval I |
| FICATION | 23. PART I. Enter the disabock, or he IMMEDIATE CAUSE (Find disease or condition resulting in dasth) Sequentially list condition if any, leading to immediate cause. Enter UNDERLYIF CAUSE (Disease or Injur | neesea, or eart fellure. al | e. A CUTE OUE TO (b. COROA DUE TO (c. DIA BU | COR AS A CO | DOMESTICE OF ARTE | 16000 CDIAL P: RY DI CLITUS | O Annapolicode of dying, su NEARC SEASE | is Road ch as cardiac or | Bowie | Marz | Approxin Interval I Onset ar |
| RTIFICATION | 23. PART I. Enter the disabock, or he immediate CAUSE (Findlesse or condition resulting in dasth) Sequentially list condition if any, leeding to immedicause. Enter UNDERLYIP | ona, | e. A CUTE OUE TO (b. COROA DUE TO (c. DIA BU | COR AS A CO | OCAR DISSECUENCE OF | 16000 CDIAL P: RY DI CLITUS | O Annapolicode of dying, su NEARC SEASE | is Road ch as cardiac or | Bowie | Marz | Approxir Interval I |
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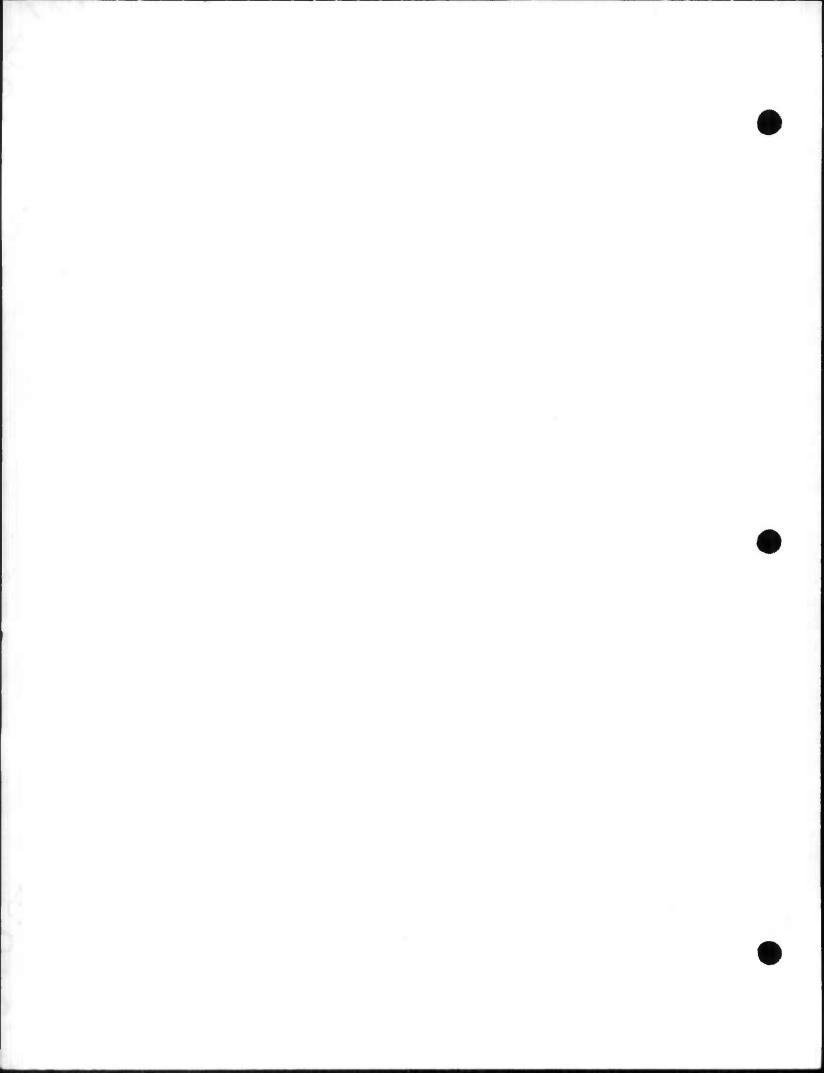
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIEN | | | | | |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------|----------------------------------------|------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | John Jackson | | | 2. DATE OF DEATH | AY YEAR | 3. TIME OF DEATH 6:10A M | | | |
| | 4. SOCIAL SECURITY NUMBER 230–26–9848 | 5. SEX 6. AGE (| In yrs. last birthday) IF | UNDER 1 YEAR IF UNDER 24 HRS ITHS DAYS HOURS MIN. | | 8. BIRTH Count | IPLACE (State or Foreign | | | |
| TOR | 9a. FACILITY NAME (If not institution, give str 6902 Sunnyside Lai | | | city, town or Location of t. Washington | | Prince G | EATH | | | |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNTY | e George's | , | Vashington | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| IERAL | 6902 Sunnyside Lai | ne | | 10f. ZIP CODE 20744 | | USA | WHAT COUNTRY? | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | 13. WAS DECENDENT OF HISP If yes, specify Cuben, Mex 1 VES 2 NO Spe | can, Puerto Rican, etc.) | or No 14. RACI Black Socc Whi | E — American Indian, k, White, atc. ify: | | | |
| COMPLETED | 15. DECEDENT'S EDUC, (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | life. Do NOT use rei | done during most of working ired.) | | SINESS/INDUSTRY | | | | |
| COMP | 12th 17. FATHER'S NAME (First, Middle, Last) | | Secretary | Treasurer 18. MOTHER'S | Barber: | Surname) | nion | | | |
| BE | Hilrey L. 19a. INFORMANT'S NAME (Type/Print) | ynch | 19b. MAILING ADI | PRESS (Street and Number or Run | ginia Jessi al Route Number, City or Tow | | | | | |
| 5 | Martha D. Lynch | | | nyside Lane | | | | | | |
| | 20e, METHOD OF DISPOSITION 1) Surfel 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | val from State Com | PLACEAND DATE OF DI etery, crematory or other p entennial | SPOSITION (Name of Church Cem. 8 | DATE 20c. LO | COV. Viro | wn, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | Kalax | 0/ | 22. NAME AND ADDRESS OF George P. Kal 6160 Oxon Hil | as Funeral | Home | | | | |
| | 23. PART I. Enter the seese, or contained, or least failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) | iat only ona causa on a | ich lina. | enter the mode of dying, so | | | Approximate interval Between Onset and Death | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. Pascular - dependent diabetes mellitus 1 yes 2 \$\times no. 1 yes 2 \$\times n | | | | | | | | | |
| IAN: | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL | | F DEATH YES | | IN 🗆 | | | | | |
| YSIC | 1 XX YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | 0.7 | HER: VARiesIdenc | 6 Cother (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Metural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW I | NJURY OCCURED | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e, PLACE OF INJURY building, stc. (Spec | — At home, farm, atree f(y) | , lactory, offica | 281, LOCATION (Street and City or Town, State) | | Route Number, | | | |
| COMPLETED | | | | the time, data and place, and d my opinion, death occured at il | | |) and manner as stated. | | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | J. San for | 2 your | 29c. LICENSE N | UMBER | 29d. DATE SIGNED 8/18/ | | | | |
| | J. Sanford Young | M.D. 11701 | Livingston | Rd. Ft. Wash | ington, Md. | | | | | |
| | AUG 21 1995 | 32 HEGISTRAN'S SIGN | ATURE) | | | | | | | |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within EV hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68769

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| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEAT | н | 3. TIME OF DEATH | | |
| | REMBERT JEROME | | I | Lewis | , JR. | August | 6 1995 | 11:58 PM | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. lest b | irthday) IF UN | DER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF BIRTH | | BIRTHEN ACE (Chair on Familia) | | |
| | 216-38-7810 ¹XX№ 2 ☐ F 9s. FACILITY NAME (If not institution, give street and number) | 53 | YRS. MONTH | | HOURS MIN, | | | Country) MARYLAND | | |
| OR | MEMORIAL HOSPITAL | | 9b. C | | R LOCATION OF D | EATH | 9c. COUNTY | OF DEATH ALBOT | | |
| 2 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | IOc. CITY, TOW | N OD LOCAT | 1011 | | | I discussed a service | | |
| DIRECTOR | MARYLAND CAROLINE | | | ESTON | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 5031 FRAZIER NECK ROA | | | 101. | 2165 | 5 | | OF WHAT COUNTRY? | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WA | YES 2 XNO | 10 | It yes, spe | | NIC ORIGIN? (Specify in, Puerto Rican, etc. y: | | RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 8 | 15. DECEDENT'S EDUCATION | 16a. DECE | DENT'S USUAL | OCCUPATIO | N | 16b. KIND OF | BUSINESS/INDUST | 'RY | | |
| COMPLET | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | kind of work do NOT use retired | | | | | ECTRONICS | | |
| Ž | 17. FATHER'S NAME (First, Middle, Lest) | | CONSO | LIMI | | | | BCINONICD | | |
| ö | REMBERT J. LEWIS, SR. | | | | | ME (First, Middle, Mai | | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | | AAII ING ADDR | E88 (S | | Route Number, City or | | | | |
| 2 | PATRICIA S. LEWIS | | | | | | | N, MD 21655 | | |
| | 20a. METHOD OF DISPOSITION 1 1 Burlel 2 Cremetion 3 Removal from State | 20b. PLACE AND | D DATE OF DISP | OSITION (Ner | | | LOCATION - City | | | |
| | 4 Donation 6 Other (Specify) | | | | METERY | 8-10 F | ASTON, | MD 21601 | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENSEE | B CAF | CP | NEWN | AM FUNE | CRAL HOM | E, P.A | TON MD | | |
| | 23. PART I. Enter the diseases, or complications that | caused the death | n. Do not ent | er the mod | ie of dying, auc | h as cardiac or re | spiratory arrest, | Approximate | | |
| | ahock, or heert fellure. List only one ceus iMMEDIATE CAUSE (Final disease or condition | e on each line. | | | | | | Interval Between Onset and Death | | |
| | reaulting in death) - a. Ventri | Cular F | ibril | lati | on | | | 410 min | | |
| z | Arteriosclerotic Heart Disease > 1 mon | | | | | | | | | |
| 일 | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 2 | cause, Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | OR AS A CONSEQUE | INCE OF): | | | | | | | |
| | DARTY (I. Only as also Miles and as a distance of the same of the | | | | | | | | | |
| MEDICAL | PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? None 1 yes 2 No of the part II. 24b. WE ANA OUTOPSY PERFORMED? | | | | | | | | | |
| W | | | | | | | | OF DEATH? | | |
| | DID TOBACCO USE CONTRIBUTE TO CAU | ISE OF DEATH | YES 🗆 | NO 🗆 | UNCERTAIL | V E | | | | |
| 등 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE C | OF DEATH (Che | | | | | | | |
| Z N | 1 X YES 2 □ NO 1 □ Inpetient 2 X I | ER/Outpatient 3 🗆 | DOA 4 N | | 5 🗆 Residence | 6 Other (Specify) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 28s. DATE OF IN (Month, Day) | | 86. TIME OF INJURY | 28c. INJU WOF | IRY AT | 28d. DESCRIBE HO | W INJURY OCCURE | D | | |
| à l | 1 Naturel 5 Pending 2 Accident Investigation | | М | | ES 2 NO | | | | | |
| | 3 Suicide 8 Could not ba 4 Homicide determined | , farm, street, f | actory, office | | 28f. LOCATION (Str. City or Town, St | eet and Number or R ate) | tural Route Number, | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of m one) 2 MEDICAL EXAMINER: On the basic of examiner. | | | | | | | useful and manner as added | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | |
| 8 | | - M T | | | D 1093 | | | GNED (Month, Day, Year) | | |
| ၉ | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE | OF OFATH STEM S | | | D 1037 | 70 | Aug | ust 7,1995 | | |
| | Robert W. Trever, M.D. | 7696 | | Gat | eway I | Easton,N | 1D 2160 | 1 | | |
| | 31. DATE FILED (Month, Day, Year) ALIG - 8 1995 July 22. FEGISTRAP | S SIGNATURES | fall | | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

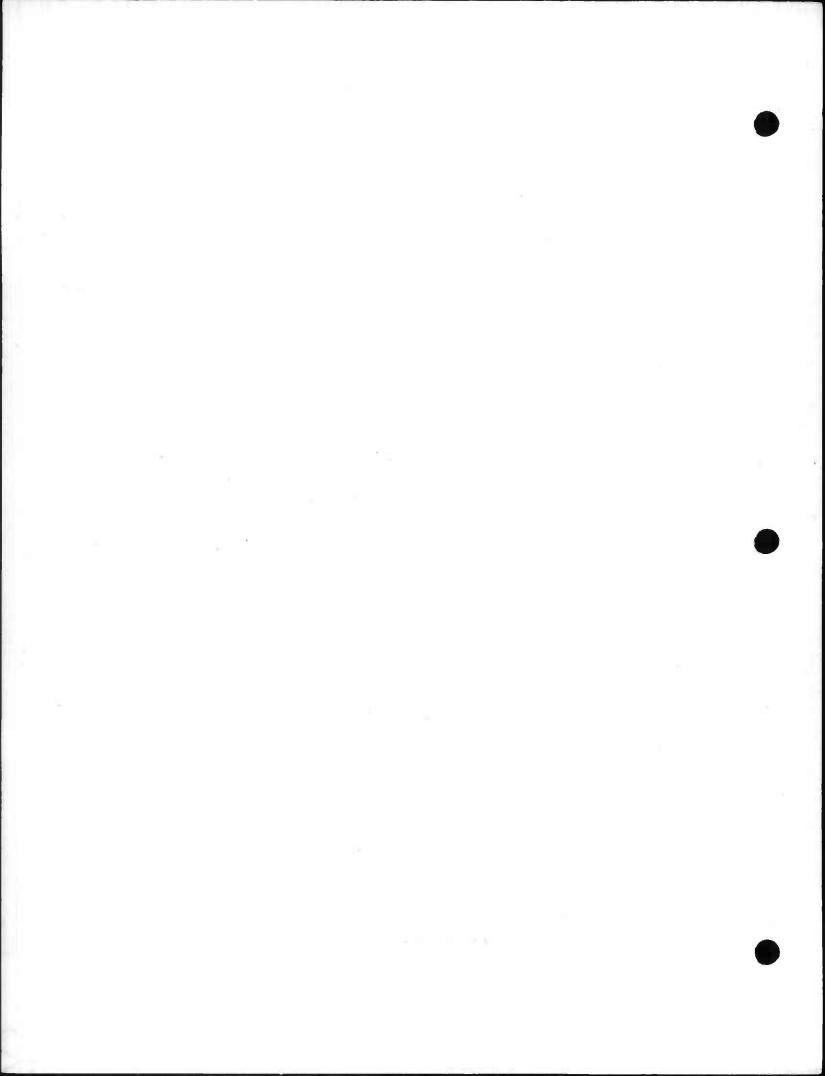
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| PHYSICIAN: The law require | S |
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d by the hospital or attending physician. Id be detached for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an nouns after death. Page to may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|--------------|-----------------------------------------------------|----------|
| REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | |
| | Francis J | Latham | | | | August 18 | | 1995 | 12:20 a.m. M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (| n yrs. lest birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHE | LACE (State or Foreign | |
| | 577-26-3853 | 1 № M 2 🗆 F 95 | 3 YRS. | ONTHS DAYS | HOURS MIN, | Feb. 8, 1 | 902 | Mar | vland | |
| | 9s. FACILITY NAME (If not institution, give a | | | b. CITY, TOWN C | PR LOCATION OF DE | | | NTY OF DE | | |
| E C | St. Mary's Nursing (| Center | | Leonardt | nwn | | St. | Mary | g | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | 00. | TALY | 5 | |
| E | 10a. STATE 10b. COUNT | | 10c. CITY, | TOWN DR LOCAT | ION | | | | 10d. INSIDE CITY LIMITS? | |
| | | lary's County | Leon | nardtow | | | | | 1 YES 2 NO | |
| FUNERAL | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CITI | ZEN OF W | HAT COUNTRY? | |
| Ä | 550 Peabody Stre | | | | 20650 | | | ted S | tates | |
| F | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | | | | IIC ORIGIN? (Specify Yes | or No- | 14. RACE Black, | - American Indian, White, etc. | |
| В | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES TE | | 2 ND Specify | | - 4 | Specify | | |
| | 15. DECEDENT'S EDU | CATION | 16a, DECEDENT'S US | LIAL OCCUPATION | M1 | Table Visit of Bull | 1 | | White | |
| | (Specify only highest grade | completed) | (Give kind of wor | k done during ma | st of working | 16b, KIND OF BUS | SINESS/INC | USTRY | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Taxi Dr | | | Taxi S | ormi. | 20 | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | TAXI DI. | rver | 18 MOTHED'S NA | ME (First, Middle, Maiden | | - | | |
| | Frank Latham | | | | Sarah H | | ourname) | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | - | 19b. MAILING AI | OORESS (Street a | | Route Number, City or Tow | n Ctata 7/n | Codel | | |
| 2 | Marie A. Smiley | | | | | ver Spring | | | d 20902 | |
| | 20a. METHOD OF DISPOSITION | 20b | PLACE AND DATE OF | | | | CATION — | | | |
| | 1 X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | noval from State cem | etery cremetory or other | r nlacel | | 1/95 Bre | | | | |
| | 21. SIGNATURE OF TUNERAL SERVICE LA | CONSEE | DIE BINCO | 22. NAME AT | O ADDRESS OF FA | CILITY | | | aryrand | |
| | A Line X | · Oolinia | 11 11 | | | Funeral Ho | | | | |
| | CAMA.X | Source | | 3401 | <u>Bladensb</u> | urg Rd., B | rent | wood, | MD 20722 | |
| | 23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final | List only one cause on e | ech line. | | | | | | Approximate Interval Between Onset and Dasth | |
| | disease or condition resulting in death) | disease or condition | | | | | | | | |
| , | _ | | N | + | C = 14- | | | | 1 | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | 1 | 20,0 | ~ | | | 1 | |
| 8 | csuse. Enter UNDERLYING | | | | | | | | 1 | |
| Ĕ | CAUSE (Disesse or injury thet initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| | resulting in death) LAST | resulting in death) LAST | | | | | | | | |
| | PART ii. Other significent condition | ns contribution to death b | ut not reculting in | the underlying | | Pa-1 | | T | | |
| SA | Salar | | or nor resorting in | the underlying | cause given in | Part i. 24s. WAS AN PERFOR | | 1 | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| ا ۾ | | | | | | 1 YES 2 | (NO | | COMPLETION OF CAUSE OF DEATH? | |
| Σ | DID TODA COO LICE | CONTRACTOR TO | | | | | 0 | | T YES 2 THE | |
| ä | DID TOBACCO USE | COMIKIBULE 10 | CAUSE OF I | | | 41 | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | C | 28. PL | ACE OF DEATH (Ch | eck only one) | | | | |
| ∑ | 1 YES 2 NO | 1 Inpatient 2 ER/Outp | etlant 3 DDA 4 | Jursing Hom | | 6 Other (Specify) | | | | |
| | 1 MANNEH OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WO | RK? | 28d. DESCRIBE HOW I | NJURY OCC | CUREO | | |
| M | 2 Accident Investigation | *************************************** | | | ES 2 ND | | | | | |
| ا ۾ | | Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | ute Number, | |
| щΙ | 3 Suicide 6 Could not be 4 Homicide determined | bullating, etc. (Spec | | | | | | | | |
| | 4 Homicide determined | | | | | | | | | |
| APLETE | 4 Homicide determined 29a, CERTIFIER Check only 1 CERTIFYING PHYS | ICIAN: To the best of my knowl | | | | | | | | |
| COMPLETE | 4 Homicide determined 29a, CERTIFIER Check only 1 CERTIFYING PHYS | | | | | | | | and manner as stated. | |
| | 4 Homicide determined 29a. CERTIFIER Check only 1 CERTIFYING PHYS | ICIAN: To the best of my knowle | | | | time, data and place, an | d due to th | e cause(a) | and menner as stated. Month, Dey, Year) | |
| BE | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | ICIAN: To the best of my knowle | and/or investigation, | In my opinion, d | eath occured at the | time, data and place, an | d due to th | e cause(a) | | |
| BE | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH | ICIAN: To the best of my knowledge: On the best of examination | and/or investigation, | in my opinion, d | 29c. LICENSE NUM | time, data and place, | d due to th | e cause(a) | | |
| TO BE COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO James C. Boyd, I.D. | ICIAN: To the best of my knowledge: On the basis of examination in the complete Pause of DEA | ATH (ITEM 27) (Typo, Pron Street, | in my opinion, d | 29c. LICENSE NUM | time, data and place, | d due to th | e cause(a) | | |
| 8 | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH | ICIAN: To the best of my knowledge. ER: On the best of my knowledge. TO COMPLETED PAUSE OF DEA | ATH (ITEM 27) (Typo, Pron Street, | in my opinion, d | 29c. LICENSE NUM | time, data and place, | d due to th | e cause(a) | | |



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| BALLIMORE, MARTLAND ZIZIS-UUZI | th certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physical | anding physician and complete, and In by the funeral director, page 5 should be detached for use as the bunit |
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DIVISION OF VITAL RECORDS,

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Is marked,

28 Item

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Dr. Ali J. Afrookteh,

1995

31. DATE FILED (Month, Day, Year) AUG 2 5

M.D.

32. REGISTRANTS SIGNATURE

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DIRECTOR: After the hours after death was

FUNERAL (within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II

permit, Pages 1, 2, 3 should al-transit p be notified at once. medical examiner must 0 cremation, shows any injury, or other traumatic event, the burial, 2 prior Hygiene signed by the atter Health and Mental certificate has been in the State Dept. of OR ATTENDING PHYSICIAN: The law

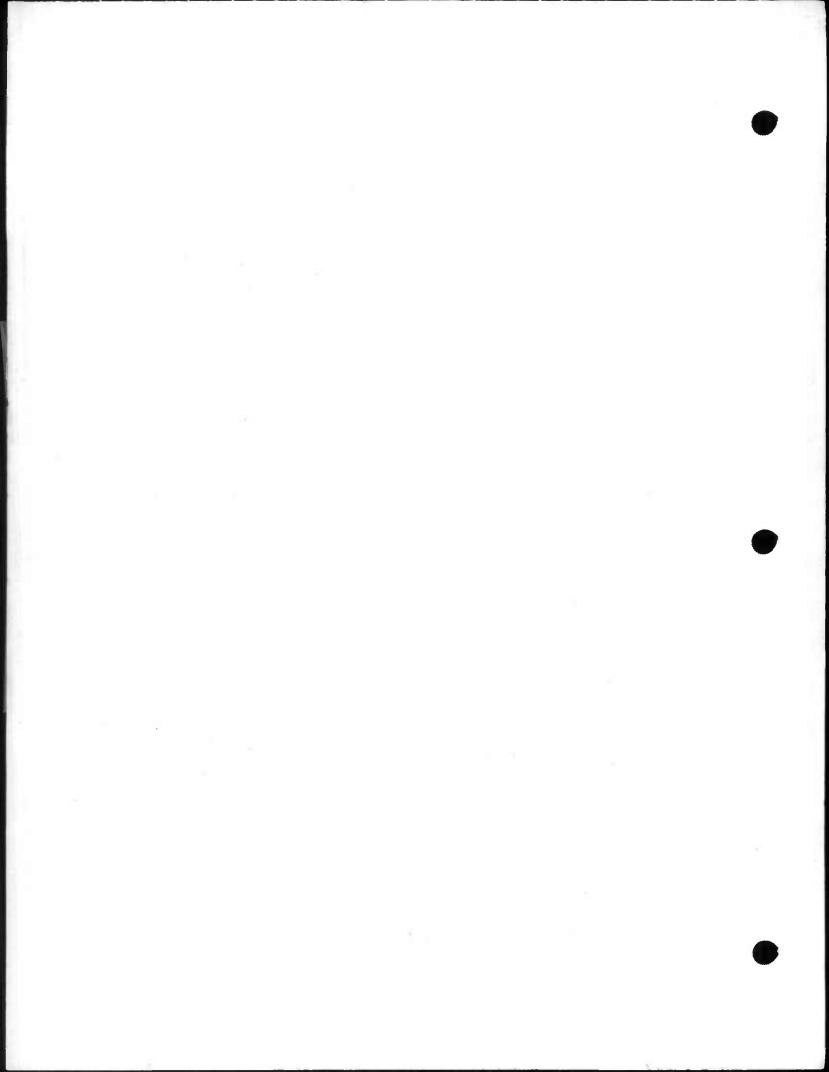
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 1995 22 4:00 pm m LONGENECKER August Hester Emma May 12, 1915 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign HOURS Pennsylvania 212-38-9332 1 - M 2 X F 9e. FACILITY NAME (If not institution, give street end number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH Frederick DIRECTOR Frederick Homewood Retirement Center RESIDENCE OF DECEDENT t0e. STATE 10b. COUNTY toc. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Frederick Frederick Maryland TY YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 21701 10001 Carroll Parkway 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES II. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION tea. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Manafacturing Company Administrative Assistant t7. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Lilliam Hahn BE Chester Clayton Doan 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 506 Fairview Avenue, Frederick, Md. 21701 Charles F. Trunk III 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 for Cremetion 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) thsburg Crematory Aug. 23 1995 Smithsburg, Md. 123 21. SIGNATURA OF FUNERAL SERVICE LICENSE Subara C Keeney & Basford P.A. Funeral Home M00021 106 E Church Street, Frederick, MD 21701 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** myeloma disease or condition tyears reaulting in death) DUE TO (OR AS A COMBEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL sonic abstructive pulmonary I TYES 2 JANG OF DEATN? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA ng Nome 5 Residence 6 Other (Specify) 4 Thu 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t Natural Pending Investigation t YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 🔲 Homicide 29e, CERTIFIER t 🗌 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated. 295. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE

▶August 23, 1995

D35183

300 West Ninth St, Frederick, Maryland 21701



hospital or attending physician. **MARYLAND 21215-0020** TIMODE

Pages 1, 2, 3

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DIVISION OF VITAL RECORDS P.O. ROX 68760

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be de be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at or |
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30, NAME AND ADD

31. DATE FILED (Month, Day, Year)

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RE AND TITLE OF CERTIFIER

AUG2 9 1995

Whim

S OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

95 27 21 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Marie Helen Lyon August 25", 1995 EAR 0405 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 216-38-3964 1 M 2 X 82 DAYS October 6, 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford Memorial Hospital Harford Havre de Grace RESIDENCE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Harford Havre de Grace 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 500 Fountain Street 21078 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Biack, White, atc. 1 Never Married 2 Married 1 | YES 2 | NO Specify: BY Specify: 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only high lege (1-4 or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital once. 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Malden Sumame) K Herbert James Clark Elizabeth Genevieve Poplar BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Bruce c. Lyon 353 Giles Street, Havre de Grace, MD 90 20a. METHOD OF DISPOSITION
1 Carrier 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE must Angel Hill Cemetery 4 ☐ Donation 6 ☐ Other (Specify) _ 8/30 Havre de Grace, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition DUE TO (OR AS A CONSEQUENCE OF huny event. regulting in death) traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) or item 196PITAL: 1 TYES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 2 Accident 5 Pending Investigation м 1 YES 2 NO BY 28a. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29a. CERTIFIER 1 SCERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

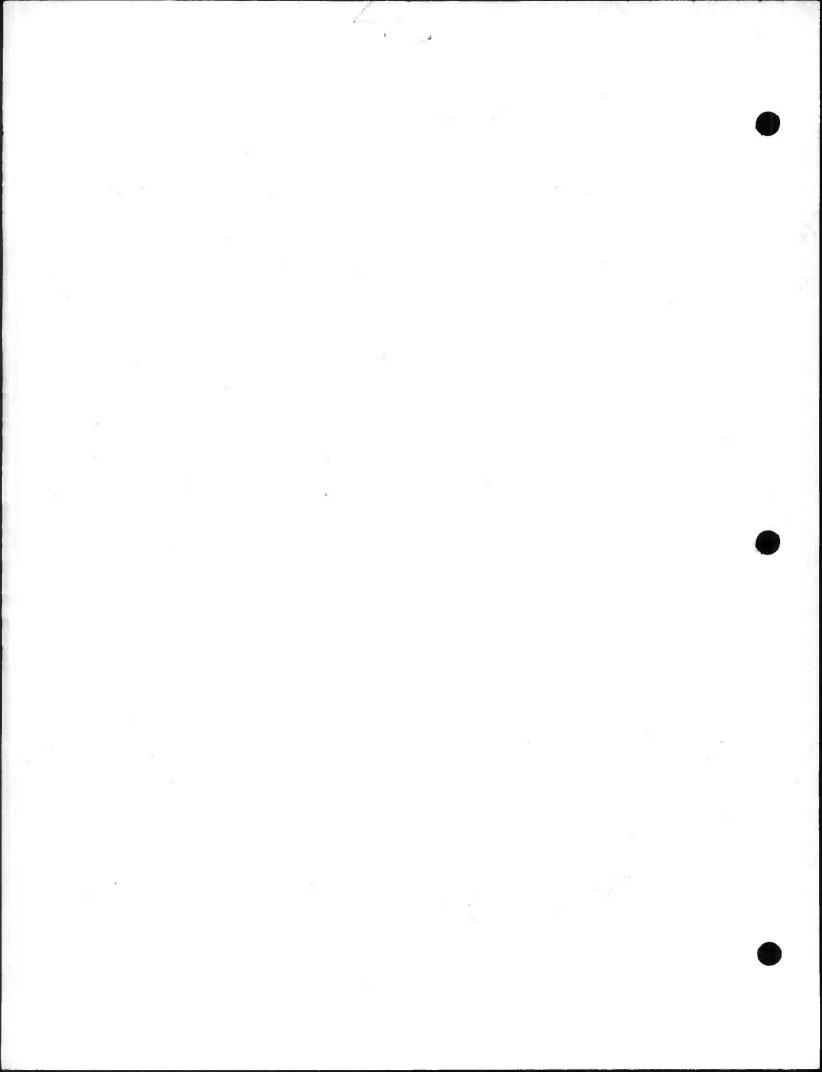
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DHMH-16 Rev 1/89

29d. DATE SONED (Month, Day, Year) 26/5K

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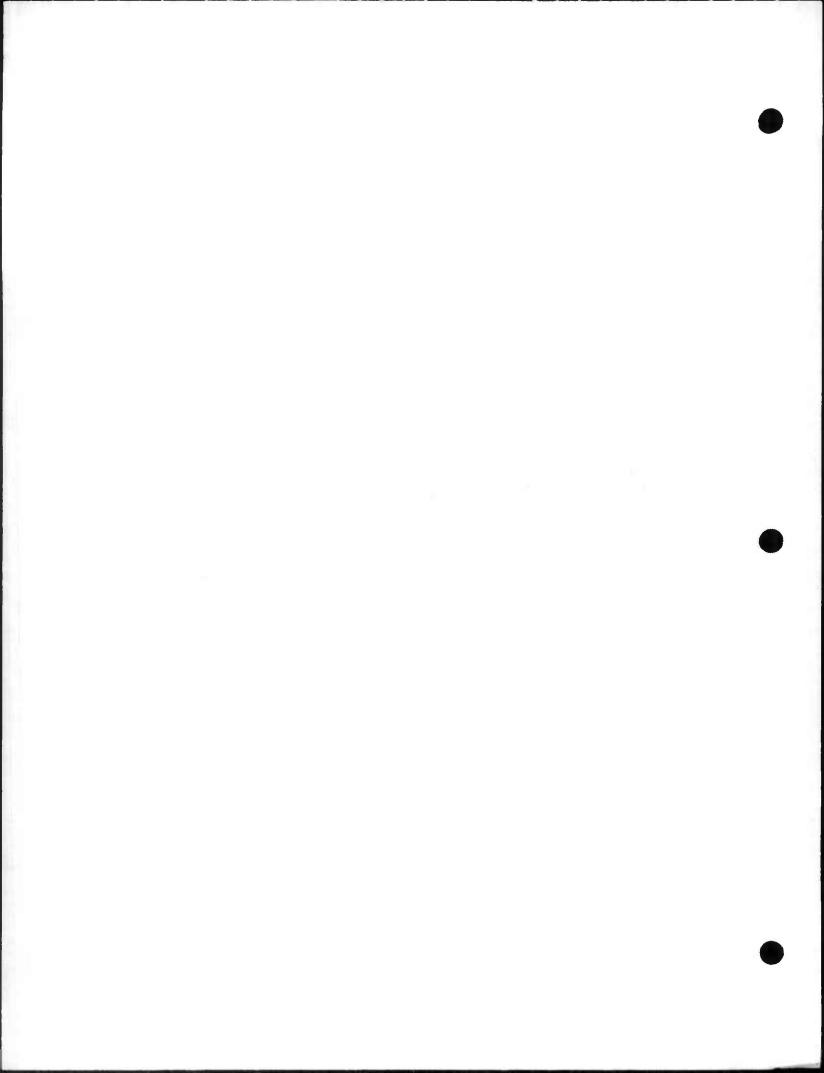
| | | 1 - STATE OF MARY | | TMENT OF HEALTI | | NTAL HYGIEN | E | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------|------------------|--------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | clair | Lint | | DATE OF DEATH MONTH DA | YEAT 2> 95 | 3. TIME OF DEATH |
| D. | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AG 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 85 YRS. | | ER 24 HRS. 7. | DATE OF BIRTH | 1.0.1.0 Coo | ATHPLACE (State or Foreign unity) nnsylvania |
| 2, 3 should | CTOR | 9a. FACILITY NAME (If not institution, give street and number) 512 Dartmouth Avenue RESIDENCE OF DECEDENT | | Silver Spr | | | 9c. COUNTY OF | DEATH |
| Pages 1, | DIREC | 10a. STATE 10b. COUNTY Missouri St. Louis | | y, town or location | | | | 10d. INSIDE CITY LIMITS? |
| sit permit. | ERAL (| 100. STREET AND NUMBER 417 Frieda Avenue | KI | 101. ZIP CO | | | | 1 YES 2 NO F WHAT COUNTRY? S.A. |
| nding physician. | BY FUNE | 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OF | S 2 XNO | 13. WAS DECENDENT If yes, specify Cut 1 YES 2 X NO | OF HISPANIC (| ORIGIN? (Specify Yes uerto Rican, etc.) | or No 14. R/ Bi | ACE — American Indian, ack, White, alc. |
| of or after | PLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | 16a. DECEDENT'S (Give kind of v life. Do NOT us Engine | · · | king | McDonne | INESS/INDUSTRY | , |
| be det | BE COMPL | 17. FATHER'S NAME (First, Middle, Last) Albert E. Linton | | 18. Mo Eth | el Sin | First, Middle, Melden : Clair | Surname) | 5-40 |
| retain 5 sho | 5 | Jamesen L. Goodman | 512 Da | ADDRESS (Street and Numb | | lver Spr | ing,Mar | |
| Page 6 ma al director, p | | | ROB. PLACE AND DATE Commetery, crematory or of Metropolit | of Disposition (Name of ther place) tan Cremator 22. NAME AND ADDR | | /95 Ale: | xandria | Town, Stata , Virginia |
| death. | | Steven Strong | | Francis J 500 Unive | . Coll ersity | ins Fune: Blvd.,W. | Sil.Sp: | e, Inc. r.,MD 20901 |
| within 24 npletely fill cremation, vent, the | | 23. PART I. Enter the diseases, or complications that cause shock, or heart failure. List only one cause on IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AL | each line. | c(evelie | | | | Approximate Interval Between Onset and Death |
| certificate be execuding physician and Hygiene prior to bur raumatic | ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | S A CONSEQUENCE OF | | | | | |
| he death the atte Mental | EDICAL CE | PART II. Other aignificant conditions contributing to death | but not resulting i | n the underlying cause | given in Par | 24a, WAS AN / PERFOR | MED? | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ATTENDING PHYSICIAN: The law requires that it scrifting has been signed by a safter death with the State Deor, of Heath and 28 is marked, or item 23 shows any in | Σ | DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL | OF DEATH YE | | CERTAIN | 3 | | 1 YES 2 NO |
| SICIAN: TI certificate the State | PHYSICIAN: | ## HOSPITAL: 1 VES 2 NO 1 Inpetient 2 ER/OR 27. MANNER OF DEATH 26s. DATE OF INJUR | | OTHER: 4 Nursing Home 5 FE | | Other (Specify) | IIIBA OCCIBED | |
| VDING PHYS After this death with | D BY P | 1 Netural 5 Pending (Month, Day, Year 2 Accident Investigation 3 Suicide 6 Could not be 26s. PLACE OF INJUNISHING per Co. | RY — At home, larm, s | WORK? M 1 YES 2 | □ NO | LOCATION (Street as | | al Route Number |
| R G D D | W | 4 Homicide detarmined Building, atc. (S) | pecify) | | | City or Town, State) | | Thousand The Control of the Control |
| HOSPITAL FUNERAL WITHIN 72 | COMPLET | 298. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examinate control of of examinate contro | | n, in my opinion, death occi | ared at the time | , data and place, and | dua to the cause | |
| TO THE TO THE De filed MPOR | TO BE | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF | DEATH STEM ST. (See | De De | SENSE NUMBER | 46 | PAUS | ED (Month, Day, Wer) |
| -0 | | 31. DATE FILED (Moritin, Day, Your) 1, 32 REGISTRAR'S DAY | 82(8) | | ons | NA | ce T | 3 Hode |
| | | AUG 25 1995 July Davelson Re | rdall | | | | | |

D Stance (

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | ALGISTAAN | | Ci | SHIIF | CALE | F DEATH | | REG. NO | | | |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------|-------------------|----------------------------------|-----------------------------------------|--------------|-----------------------|--------------|------------------------|------------------------------------------------------------------------|
| | 1. DECEDENT'S HAME (First, Middle, Last) | | | | | | 2. DATE | OF DEATH | W | YEAR 3. | TIME OF OEATH |
| | Theresa | М. | | Lang | gis | | Augu | | Ž, 19 | 95 | 12:57 P. |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER 1 YEAR | | | OF BIRTH | | | ACE (State or Foreign |
| | 217-42-8704 | 1 M 2 X F | 85 | YRS. | MONTHS DAYS | HOURS MIN. | | 7 31, 1 | 910 | Country) Ma: | ine |
| | 8a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, TOW | OR LOCATION OF | | | | NTY OF DEAT | |
| 8 | Montgomery Gen | eral Hospi | tal | i | (| Olney | | | Mo | ntgom | arv |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | | | | | | | 110 | negom | ery |
| DIRECTOR | | | | - | , TOWN OR LO | | | | | 10 | d. INSIDE CITY LIMITS? |
| - 1 | Maryland | Но | ward | W | oodbine | 2 | | | | 1 | YES 2 NO |
| FUNERAL | 10e. STREET AHD HUMBER | | | | | 101. ZIP CODE | | | 10g. CITI | ZEN OF WHA | T COUHTRY? |
| W | 3247 Starting Gat | T | | | | 21797 | | | | ted St | ates |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT FORCES? 1 | | | 13. WAS D | ECENOENT OF HISP specify Cuban, Maxi | ANIC ORIGI | N? (Specify Yes | or No- | 14. RACE — Bleck, W | American Indian, hits, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WA | R OR DATES | | | ES 2 X HO Spe | | Thousand areas | - 1 | Specify: | |
| 60 | 15, OECEDENT'S EDU | I CATION | 10.00 | | | | | | | | White |
| ETE | (Specify only highest grade | e completed) | /G | | USUAL OCCUPA rork done during | | 168 | . KIHD OF BUS | SIHESS/IHD | DUSTRY | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5+) | 1 | | , | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | Home | maker | | | | wn Ho | me | |
| | Is. MOTHER'S HAM | | | | | | | | | | |
| BE | Joseph 19a. IHFORMANT'S HAME (Type/Print) | Fortin | | | | | | <u>lorida</u> | | | |
| 2 | | t and Number or Run | | - | | | | | | | |
| | Collette Sourth | lard | | | | ne Road, | | | | | |
| | 1 Buriel 2 Cremation 3 Ren | novel from State | cemetery, cre. | matory or off | F DISPOSITION (| | DAT | | | City or Town, | |
| | 4 Constion 5 Other (Specify) Fairview Cemetery 8/25 Mann Township, PA. | | | | | | | | | | |
| | DeVol Funeral Home | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| RTIFICATION | disease or condition resulting in death) a. A deno carcino ma Lung with metastrus; Due to (or as a consequence of): A cute Myo cardial Tenfarction Due to (or as a consequence of): CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| G | PART II Other elections and disc | | | | | | | | | | |
| MEDICAL | Hypertensic | | aath but not n | eauiting in | n tha underly | ing ceusa given i | n Part i. | 24a, WAS AN PERFOR | MED? | AM CO OF | RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| ż | DID TOBACCO USE CONT | RIBUTE TO CAU | SE OF DEA | TH YE | ON 🗷 8 | UNCERTA | IN 🗆 | | | | , |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | | H (Check only on | e) | | | | | |
| YS! | 1 TYES 2 HO | 1 Inpetient 2 | ER/Outpetlant 3 | | OTHER: 4 - Hursing He | ome 6 🗆 Rasidenci | 6 🗆 Othe | r (Specify) | | | |
| ву рну | 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation | 26s. DATE OF III (Month, Day, | JURY Year) | 26b. TIME INJU | JRY V | NJURY AT VORK? YES 2 NO | 28d. DE | CRIBE HOW IN | JURY OCC | CURED | |
| W I | 2 Accident Investigation 3 Suicide 6 Could not be detarmined 4 Homicide detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | Number, | | |
| TED | - Could not be | bullaring, at | () | | | | | | | | |
| TO BE COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AHD TITLE OF CERTIFIE | ICIAN: To the best of m | y knowledge, de | nvestigation | , in my opinion | death occured at the | e time, data | | f dua to the | a cause(s) an | d manner as stated. |



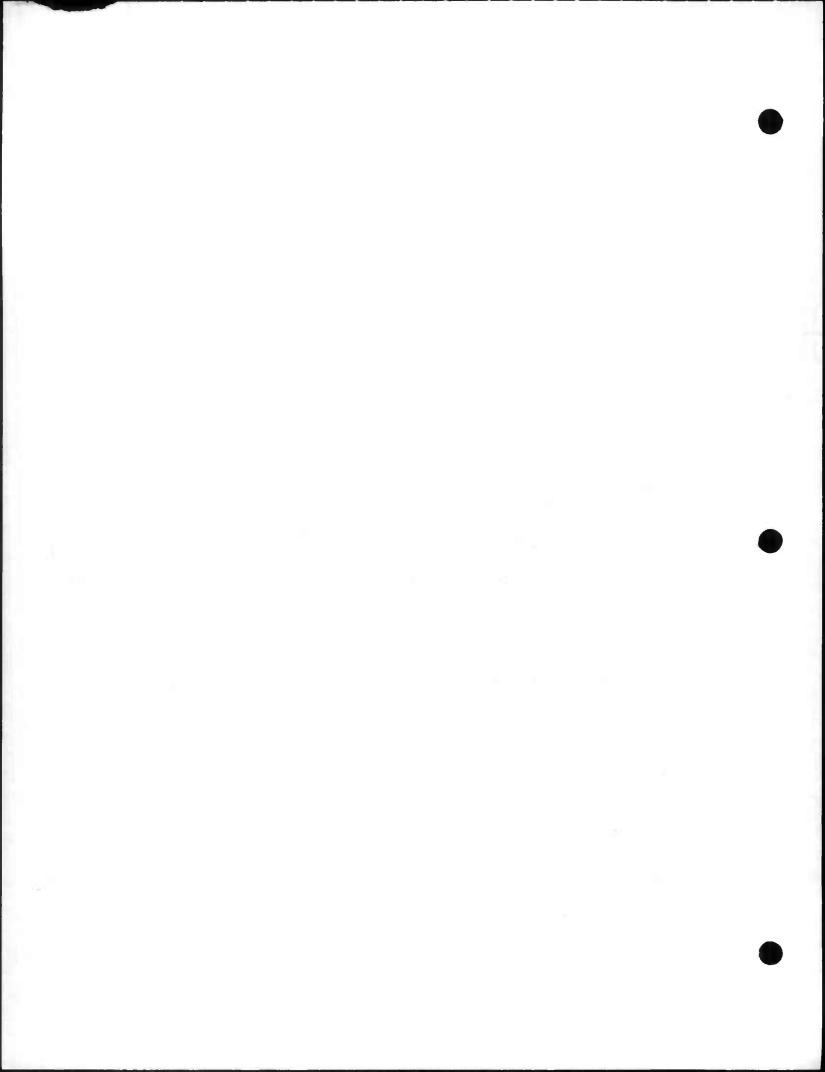
y be retained by the hospital or attending physician, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 724 hours after death. Page 6 may be retained by the hospital or attending physician. | RECTOR: A urs after d | IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL | TO THE FUNERAL DI | IMPORTANT: If | |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPART CERTIFIC | MENT OF H | EALTH AND | MENTAL HYGIEN | | | | | |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------|--------------------------------------|---------------------------|---------------------|----------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | <u> </u> | JAIL OI | DEATH | 2. DATE OF DEATH | ·. | 3. TIME OF DEATH | | | |
| | Mae K. Legler | | | | | | 7. 1995 | 12:50 A M | | | |
| | | 6. SEX 6. AGE (| n yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | THPLACE (State or Foreign | | | |
| | 184-09-0663 | □ M 2 X F 9 | 2 YRS. | ONTHS DAYS | HOURS MIN. | July 3, 1 | QO3 Pan | nsylvania | | | |
| | Se. FACILITY NAME (If not institution, give stree | | | b. CITY, TOWN C | OR LOCATION OF DI | | 9c. COUNTY OF | | | | |
| DIRECTOR | Montgomery Genera | l Hospital | | Silve | r Spring | 3 | Montgomery | | | | |
| Ä | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? | | | |
| | Maryland Montgo | | | | | | 1 YES 2 X NO | | | | |
| R | 15107 Interlacher | n Dudana #2 | 20 | " | 20906 | | | | | | |
| FUNERAL | 15107 Interlacher | 2. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | | VIC ORIGIN? (Specify Ye | | d States | | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | Il yes, spi | cify Cuben, Mexica 2 🗓 NO Specifi | n, Puerto Rican, etc.) | Sta | Black, White, etc. | | | |
| BY | 3 🔀 Widowed 4 🗌 Divorced | ii 120, GIVE WAN ON DA | 1123 | I U TES | 2 M NO Specif | γ: | Spe | White | | | |
| ED | 15. DECEDENT'S EDUCAT (Specify only highest grade cor | TION TOO INTO THE TOO IN TOO I | 16a. DECEDENT'S US | BUAL OCCUPATION done during mo | ON . | 166, KIND OF BU | SINESS/INDUSTRY | | | | |
| Ē | | College (1-4 or 5+) | He. Do NOT use | retired.) | st of working | | | | | | |
| MP | | 2 | Self E | mployed | | Hard | lware | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S NA | ME (First, Middle, Melden | Surname) | | | | |
| BE (| William Phillips | | | | Rebec | ca Smith | | | | | |
| 0 | 19s. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING A | DDRESS (Street e | nd Number or Rural i | Route Number, City or Tox | m, State, Zip Code) | | | | |
| - | Carol W. Friedman | | 3807 D | unsinan | e Drive, | Silver Sp | oring, Ma | aryland 20906 | | | |
| | 20a METHOD OF DISPOSITION 1 | 20b. | PLACE AND DATE OF | DISPOSITION (Na | ust 21, | 1995 20c. LC | CATION - City or | | | | |
| | 4 Donation 5 Other (Specify) | A Donation 5 Other (Specify) Riverside Cemetery Norristown, PA | | | | | | | | | |
| | Ray Lava Somo | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MUN 831 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-3501 | | | | | | | | | |
| | 23. PART I. Enter the diseases, or con | polications that caused | the death De ser | Avenu | e, Rockv | ille, Mary | land 208 | | | | |
| | shock, or heart fallure. Lis | t only one ceuse on ea | ch line. | anter the mo | de of dying, suc | h aa cardlac or reap | iratory arrest, | Approximate interval Between | | | |
| | INMEDIATE CAMPE (Final | | | | | | | | | | |
| | resulting in death) | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | |
| ÄT | If any, leeding to immediate cause. Enter UNDERLYING | 776-10-0 | 110-110-10-1 | | | | | į į | | | |
| E | CAUSE (Disease or Injury that initiated events | CAUSE (Disease or Injury C. | | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | |
| | | d. | | | | | | | | | |
| ¥ | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? PERFORMED? | | | | | | | | | | |
| 음 | GASTADING SINAC BUELDING BRINGHIETURO | | | | | | | COMPLETION OF CAUSE OF DEATH? | | | |
| M | | | | | | | | | | | |
| ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖾 NO 🗌 UNCERTAIN 🗍 | | | | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| YSI | HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | |
| H | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED INJURY | | | | | | | | | | |
| B | 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | | |
| | 3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28l. LOCATION (Street and Number or Rural Route Nu City or Town, State) | | | | | | | | | | |
| E | 4 Homicide datermined | | | | | | | | | | |
| 립 | 29e. CERTIFIER (Check only 1 © CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end manner se stated. | | | | | | | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner es stated. | | | | | | | | | | |
| | 29b. HONATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Mo. | | | | | | | D (Month, Day, Year) | | | |
|) BE | 20m T, Cey MA 036252 | | | | | | 2 DAVEUST 17.19.95 | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) STEVEN TO KARI V4, MD, 1/50/GEORGIA AVE #575, WHEATON MD 20902 | | | | | | | | | | |
| | 31. DATE FILED MOPES Day Mary 1997 32 REGISTRAPES SIGNATURE AUG 2 1 1995 Sulva discussion handaly | | | | | | | | | | |





1 - STATE REGISTRAR

1. DECEDENT'S HAME (First, Middle, Last)

J.

5. SEX

Lam

Suwar

4. SOCIAL SECURITY HUMBER

Clara Chan M.D.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

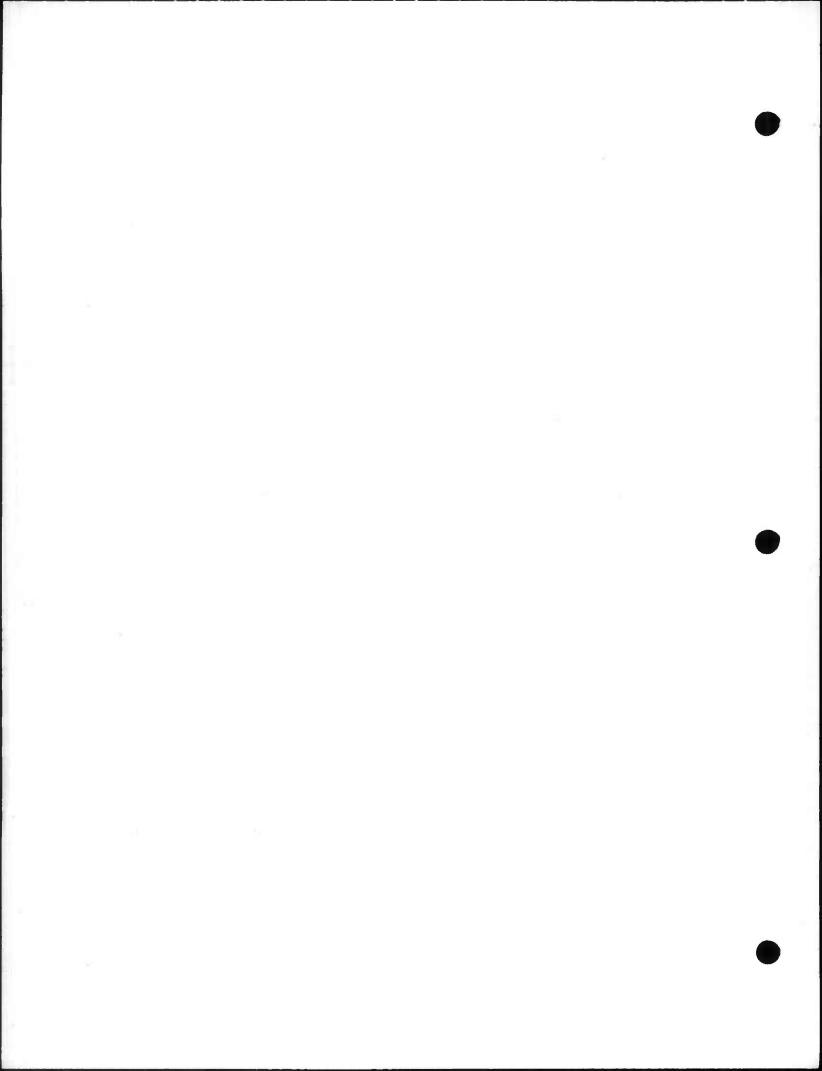
| ding physician. the burial-transit permit. Pages 1, 2, 3 should | | 210-98-1061 | | 1 M 2 2 F | | 45 | YRS. | | | | M | arch | . 28 |
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| | _ | 9s. FACILITY HAME (If not insti | | | | | | 9b. C | TY, TOWN C | R LOCATIO | OF DEAT | Н | |
| | <u> </u> | Washington Adventist Hospital Takoma Park | | | | | | | | | | | |
| | <u>ا</u> | RESIDENCE OF DECE | IOB. COUNTY | , | | | 10c. CIT | Y. TOW | OR LOCAT | IOH | | | |
| | DIRECTOR | N/A | N/ | 'A | | | | | | | | | |
| | | N/A N/A Washington, DC 100. STREET AHD NUMBER 100. ZIP CODE | | | | | | | | | | | |
| sit p | ER/ | 5500 8th Street, NW 20011 | | | | | | | | | | | |
| as the | FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IH U.S. ARMED 13. WAS DECEMBENT OF HISPANIC O | | | | | | | | | | ORIGIH? | (Specif |
| | BY F | 1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rice 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: | | | | | | | | | | an, ato | |
| as th | ED B | | | | | | | | | | | | |
| use use | TE | 15. DECEE (Specify only h | carrioH completed) | | /Gh | m kind of v | work dos | AL OCCUPATIOH done during most of working | | | | | |
| retained by the hospital or attending 5 should be detached for use as the notified at once. | P. | Elementary/Secondary (0-12 |) | Housekeeper | | | | | | | | | |
| | COMPLET | 17. FATHER'S HAME (First, Midd | de, Last) | | | 110 | user | eep | ET | 18 MOTHE | D'S HAME | | |
| | Ŭ U | Tang Huan | | | | | | | | Iee | | | |
| hould fled | m | 19a. INFORMANT'S HAME (Type | e/Print) | | | 19b | MAILING | ADDRE | SS (Street a | | | Tonight? (Specify Puerto Ricen, atc.) 16b. KIND Of Wash: Hote: E (First, Middle, Midd | |
| | 2 | Tak Leung | Lam | | | | | | | eet, | | | |
| nay be | | 20s. METHOD OF DISPOSITION | N Paris | and from Chata | INT EVER IH U.S. AR 1 YES 2 WAR OR DATES 16a. DE (G. Iffe. Iff | HD DATE (| OF DISP | OSITIOH /Ne | me of | | 770 | 7 | |
| je 6 ma irector, p | | 4 Donation 5 Other (S | pecify) | | Na Na | etery, cren 1 ti OI | natory or 8 | ther place lemo | rial | Park | 8/2 | 6/95 | (Specify, steel of the control of th |
| ter death. Page 6 may be the funeral director, page wal. | - 1 | 21. SIGNATURE OF FUNERAL | SERVICE LIE | SPISEE / | 7 | | | | | D ADDRESS | OF FACILI | TY | |
| death e fund exam | - 1 | 1 (Cerus | (1) | timel | | | | | | | | | Specify, Spe |
| S P P | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of | | | | | | | | | | | c or i |
| Do of | | ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final | | | | | | | | | | | |
| | 1 | disease or condition resulting in death) | | Metasta | atic | Nas | onha | rvn | 7697 | Carci | noma | | Fur d. W Specify (Specify) (Spe |
| completely ial, cremati avent, tl | | | Ì | DUE TO | OR AS A | CONSEO | UENCE OF | F): | e en T | varci | поша | | |
| executed within and completely be burial, crema matic event, | Z | Sequentially list condition | | b, | | | | | | | | | |
| be ex | Ĕ | th any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| certificate be execution of the physician and chygiene prior to burian other traumatic | CERTIFICATION | CAUSE (Disease or injury | | DUE TO | OR AS A | CONSEC | LIEHCE OF | E). | | | | | H? (Specify of Shing |
| 0 25 | Ē | that initiated events resulting in death) LAST | | | 011 110 11 | CONSEC | OLITICE OF | 1. | | | | | |
| E & _ 0 | | d | | | | | | | | | | | |
| by the deal and Mental | ¥. | | | | | | | | | | | | |
| uires that signed by Health and | | | | | | | | | | | | _ 1 | □ YI |
| law requires as been sign bept. of Hea 23 shows | Σ | | | | | | | | | | | _ | |
| has be Dept. | Ž | | | RIBUTE TO CA | | | | | | UNCE | RTAIN | | |
| 0 4 - | o l | 25. WAS CASE REFERRED TO I | WEDICAL | HOSPITAL: | | | | OTH | | | | | |
| ICIAN ertific | > 1 | 1 YES 2 NO | | | | atient 3 | | | _ | | 7 | | |
| DING PHYSICIAN: The After this certificate death with the State smarked, or Item | F | 1 Natural 5 Pe | | | | | WOI | Bc. INJURY AT WORK? | | id. DEŞCF | NBE H | | |
| After death | 6 | 2 Accident Investigation Three PLACE OF INJURY At home form street factors office | | | | | | | | I I OCATI | OH /0 | | |
| OR ATTENDING PHYSI DIRECTOR: After this co nours after death with tem 28 is marked, | 8 | | uid not be termined | butiding, | ntc. (Spec | lfy) | | PEFWWE, 10 | ictory, offica | | 20 | City or | Town, 3 |
| OR ATTEN DIRECTOR: hours after item 28 Is | 9 | 29a, CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) an | | | | | | | | | | | |
| 3 4 Z = | COMPLET | (Check only | | | | | | | | | | | |
| THE HOSPITAL THE FUNERAL filed within 72 h PORTANT: If i | 111 | 296. SIGNATURE AND TITLE OF | | 11 | | | | , | T | | | | та ринс |
| 五年 100 | 8 | /// / | 0 | 11/10 | 1 | | K | 1 | | D418 | | R | |
| ₽₽2₹ | 일 | 30. HAME AND ADDRESS OF P | ERSON WHO | COMPLETED CAUS | E OF DE | ATH (ITEM | 27) (Type. | Print) | ′ | D410. | 40 | - | |
| | | | | | | | | | | | | | |

7525 Greenway Center Drive, Greenbelt, MD

32 REGISTEAR'S EIGNATURES

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1995 August 18 1355 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8,1950 Thailand 9c. COUNTY OF DEATH Montgomery 10d, INSIDE CITY LIMITS? 1 X YES 2 | HO 10g. CITIZEH OF WHAT COUNTRY? USA fy Yes or No— c.) 14. RACE — American Indian, Black, White, atc. Asian F BUSINESS/INDUSTRY ington Renaissance eiden Surneme) or Town, State, Zip Code) gton, DC 20011 c. LOCATION — City or Town, State alls Church, VA neral Home, Inc. Sil.Spr.MD 20901 respiratory arrest, Approximate interval Batween Onset and Death 10 Mos. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE S AN AUTOPSY ES 2 1 NO OF DEATH? 1 YES 2 NO OW INJURY OCCURED treet and Number or Rural Route Number, State) manner as stated. e, and dus to the cause(s) and manner as stated. 29d. DATE SIGHED (Month, Day, Year)

August 21, 1995



296. SIGNATURE AND

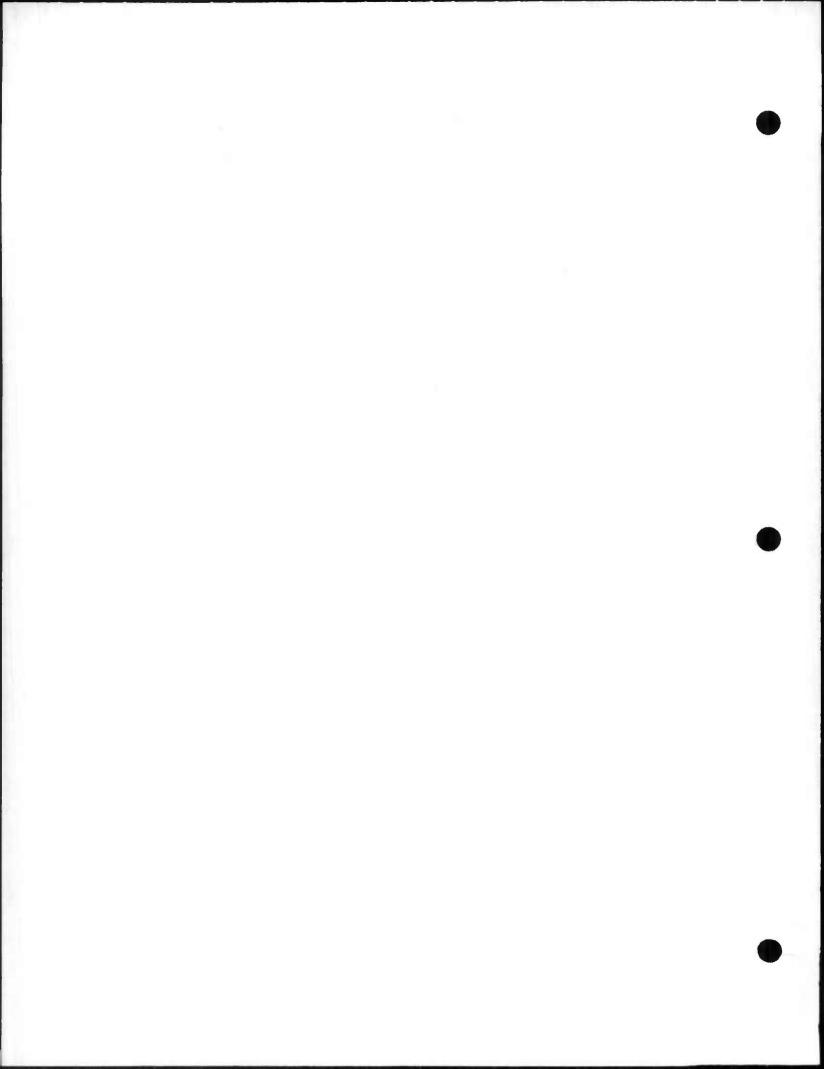
| A | mended #1 | 23/95 MARYLAND / | DEPART | MR T | HEALTH AND | ontgo Mental Hygien | 9: ner | 5 2 | 17126 Ctg. | |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------|-------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | CE | ERTIFI | CATE OF | DEATH | PEG. NO. | | () 3. T | TIME OF DEATN | |
| | 4. SOCIAL SECURITY NUMBER 5, SEX | ENE | | eses | - | AUG. 17, | 1995 | | 5:15 A M | |
| | 251-11-2731 1 □XM 2 □ F | 6. AGE (In yrs. les | _ | WONTHS DAYS | IF UNDER 24 HRS. HOURS MIN, | 7. DATE OF BIRTN (Month, Day, Year) Sept 20, 19 | 1 1 | Country) | arolina | |
| FOR | 9e. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | 96. CITY, TOWN OR LOCATION OF DI Silver Spring | | | | PEATN 9c. COUNTY OF DEA | | | |
| DIRECTOR | 106. STATE 106. COUNTY Maryland Prince George' | S | 10c. CITY, TOWN OR LOCATION Landover | | | | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | Lon | | Of. ZIP CODE | | 10g. CITIZEN | | YES 2 NO | |
| R | 3133 - 75th Avenue #1 | | 20740 | | | | United | | | |
| B⊀ | | X YES 2 N | YES 2 □NO If yes, specify Cuban, Mexica R OR DATES 1 □ YES 2 [¥] NO Specify | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Coffege (1-4 or 5 + | (Gi life. | 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | | Building Construction | | | tion | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Malachi | Lesesne | 16. MOTHER'S N | | | AME (First, Middle, Meiden Surname) Lee Boatwright | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | | | and Number or Rural I | Route Number, City or Town | | | | |
| F | Malachi Lesesne 104 W. Liberty St., Florence, SC 29501 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Surlei 2 □ Cremation 3 □ Removal from State 4 □ Donation, 5 □ Other (Specify) | 20b. PLACE A cemetery, cred | 20b. PLACEANDDATE OF DISPOSITION (Name of cametery, crematory, or other place) U.S. National Cemetery | | | | DATE 20c. LOCATION — City or Town, State Florence, SC | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | MOC | Rapp Funeral Service M00827 933 Gist Ave, Silve | | | | | MD 2 | 20910 | |
| | 23. Apri i. Enter the diseases, or complications that shock, or heart fellure. Liet only one ceu immediate Cause (Final disease or condition resulting in death) | se on each line. | | ot anter the m | ode of dying, suci | | retory arrest, | | Approximate interval Between Onset and Daeth | |
| N | Pro | foil we w courses | Pecton in abdoman | | | | | | one day | |
| CATION | cause. Enter UNDERLYING | Pech | | | | | | | | |
| CERTIFI | that initiated events resulting in death) LAST | collec | Nas a consequence of: Lollecton & fluid in about | | | | | | | |
| PHYSICIAN: MEDICAL C | - Malvalation - Poor Per fermonal Status | | | | | | COMI OF D | E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH Netural 5 Pending 28e. DATE OF (Month), Decident 1 Accident 1 | INJURY | URY 28b. TIME OF 28c. INJURY AT | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| | 3 Suicide 26e. PLACE Of | FINJURY — At honetc. (Specify) | ne, lerm, str | eet, fectory, offic | De | 28f. LOCATION (Street a City or Town, Stete) | nd Number or R | lural Route I | Vumber, | |
| MPLETE | 29e. CERTIFIER (Check only one) | my knowledge, des | th occurred | at the time, date | e end place, end due | to the cause(e) end man | ner se stated. | | | |

TO BE COM 29d. DATE SIGNED (Month, Day, COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A 50 W Edmors-by 191 23 1995 140 32 REGISTRAR'S SIGNATURE 31. DATE FILED (Month).
AUG

29c. LICENSE NUMBER

DHMN-16 Rev 1/89



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

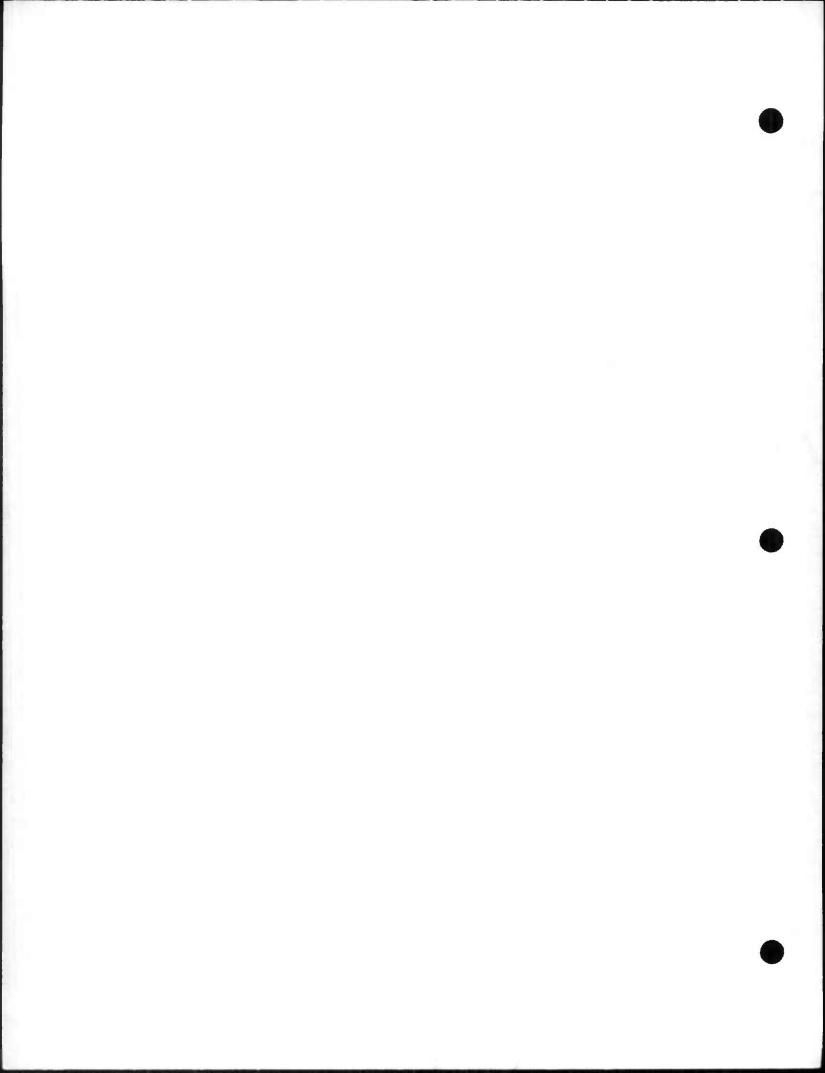
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

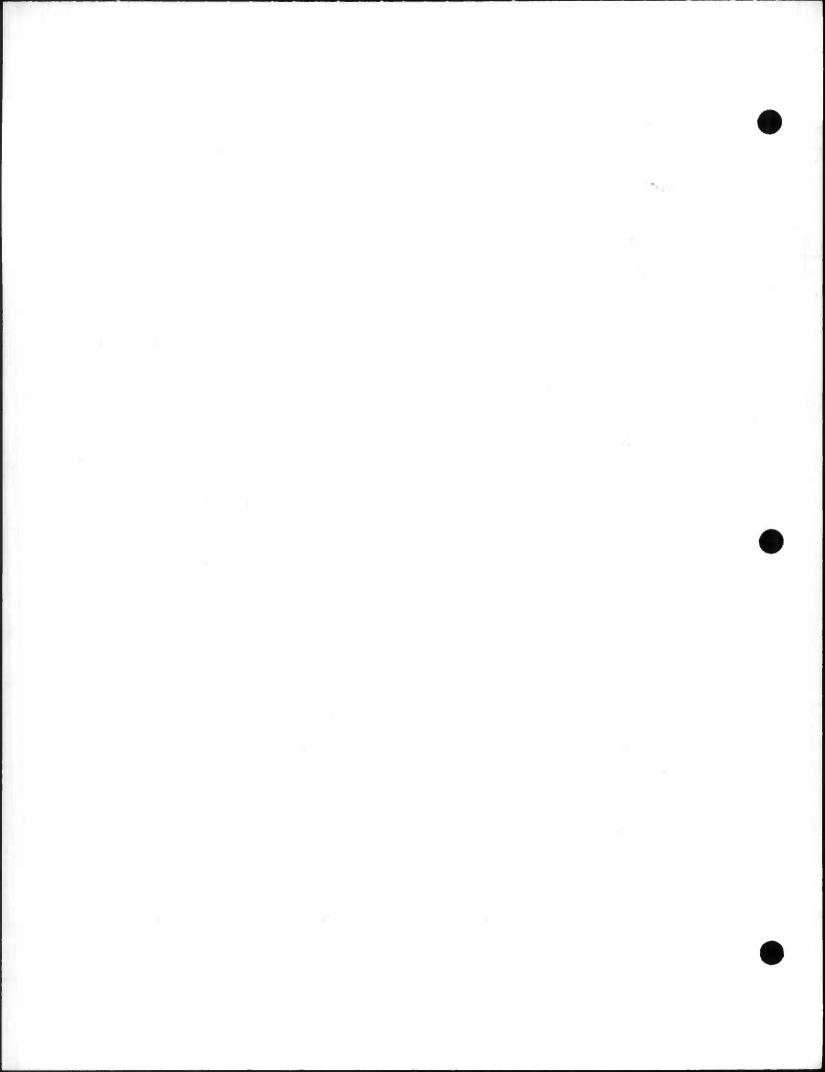
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, | , Middle, Lest) | | | | | | | | 2. DATE OF C | | | | 3. TIME OF DEATH |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|-----------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------|------------------|------------------------------|-------------|------------------------------|--------------------|-------------------------------------------|
| | | | Thomas | T. Low | e | | | | | Augus. | t 21 | , 19 | YEAR 95 | 10:30 A M |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. | last birthday) | | ER 1 YEAR IF UNDER 24 HRS. | | | 7. DATE OF BIRTH 8. BIRTHI | | | | PLACE (State or Foreign |
| | 214-03-8315 | | 1 🔀 M 2 🗌 F | 81 | YRS. | MONTHS | | | | | | | vland | |
| œ | 9e. FACILITY NAME (If not in | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE | | | | | | | |
| 5 | Holy Cross | - | ıtal | | | | Silv | er S | prin | g | | 1 | Monto | gomery |
| DIRECTOR | 10e. STATE | 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN | OR LOCA | TION | | | | | | 10d. INSIDE CITY |
| | Maryland | Mont | tgomery | | | Sil | ver | Spri | ng | | | | | LIMITS? |
| FUNERAL | 10e. STREET AND NUMBER | | | | | | 10 | I. ZIP COD | E | | | 10g. CIT | ZEN OF W | HAT COUNTRY? |
| Ä. | 205 Pewter | Lane | | | | | 2 | 0905 | | | | Un: | ited | States |
| | 11. MARITAL STATUS 1 Never Married 2 | Married | | YES 2 X | | 13. | WAS DEC | CENDENT C | OF HISPAN | IC ORIGIN? (Sp | etc.) | or No- | 14. RACE Black | - American Indian, , White, etc. |
| BY | 3 Widowed 4 Divo | | IF YES, GIVE V | WAR OR DATES | | | 1 TYES | 2 🙀 NO | Specify | • | . , | | Specif | y: White |
| 8 | 15. DEC | EDENT'S EDUC | CATION | | ECEDENT'S | | | | | 16b. KINI | D OF BUS | INESS/INC | DUSTRY | WILLE |
| COMPLETED | Elementary/Secondary (0 | | College (1-4 or 5 | +) A | (Give kind of fe. Do NOT u | se retired.) | during me | ost of workin | ng | | | | | |
| MP | 12 | | | | Print | er | | | | I | Prin | ting | | |
| 8 | 17. FATHER'S NAME (First, Middle, Lest) Richard Thomas Lowe Mazie Bolton | | | | | | | | | | | | | |
| BE | Richard Thomas Lowe Mazie Bolton | | | | | | | | | | | | | |
| 2 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. Dale Lowe 14501 Manor Park Drive, Rockville, Mary | | | | | | | | | | | am 4 200E2 | | |
| | 20a. METHOD OF DISPOSITI | ION | | 20h PLAC | EANDOATE | OE DISBOI | NA MOITIC | ame of | | 0.75 | | | City or Ton | |
| | 1 Donation 6 Other | | oval Irom State | cemetery, c | remetory or o | ther place) | Auc | ust | 22, _T | 1995 | | | | |
| | 21. SIGNATURE OF FUNERAL | L SERVICE LIC | ENJURE | | , | her place) August 22, 1995 y Crematorium, Inc. Bethesda, Maryland 22. NAME AND ADDRESS OF FACILITY POPERTY AND ADDRESS OF FACILIT | | | | | | | | /Darler illa |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, 300 West Montgomery Avenue Inc. Rockville. Maryland 20850-2805 | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complicatione that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | Approximate interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | Onset and Death | | |
| | resulting in death) | | | | | | | | | | l minute | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ON I | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | | | 2 years | | |
| CAT | cause Enter UNDERLYING | | | | | | | | | | | | | |
| E | CAUSE (Disease or injury that initiated events resulting in death) LAST C. AT CETTOSCIETOLIC CATGLOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| HH | | | | | | | | | | | | | | |
| AEDICAL CERTIFICATION | PART II. Other significa | nt conditions | contributing to | death but not | resulting | in the ur | derlyin | g ceuse g | given in i | Part I. 24a. | WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| S | <u> </u> | | | | | | | | | 10 | PERFORI | | | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| WE | | | | | | | | | | _ ' - | , .=0 2 | 64 | | OF DEATH? 1 YES 2 NO |
| | DID TOBACCO U | SE CONTR | RIBUTE TO CA | USE OF DE | ATH YE | S 🗆 I | NO 🗵 | UNC | ERTAIN | | | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | 26. PL/ | CE OF DEA | TH (Check | | | | | | | | |
| YSI | 1 XYES 2 NO | | 1 Inputient 2 | | | 4 🗆 Nur | | 10 5 🗆 Re | sidence (| Other (Spe | icify) | | | |
| | 27. MANNER OF DEATH 1 X Natural 5 1 | Pending | 28e. DATE OF (Month, D | | 26b. TIM | E OF URY | | PRK? | | 28d. DEŞCRIB | E HOW IN | JURY OCC | CURED | |
| B | 2 Accident | nvestigation | 28e PLACE O | F INJURY — At h | ome from | Henry Inch | | YES 2 | NO | | 1 (0) | | | |
| | | Could not be letermined | building, | etc. (Specify) | ome, reim, | errege, raci | ory, orne | • | | 281. LOCATION City or Tow | rn, State) | nd Number | or Hural Ho | oute Number, |
| ۳ | 29e. CERTIFIER TEX CERTI | IFYING PHYSIC | ZIAN: To the best of | mu knowledne a | lasth assum | 4 -4 -4 - 4 | | | | | 14.55 | | 7. | |
| COMPLETE | | | | | | | | | | | | | | end manner on stated. |
| | | | | | | | | | | | | | (Month, Day, Year) | |
| O BE | SI | | | | Dl | 7368 | | | | | st 22, 1995 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |
| | Stanley A. Schwartz, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815 | | | | | | | | | | | | | |
| | AUG 23 1995 AUG 23 1995 AUG 28 1995 | | | | | | | | | | | | | |



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| | | FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTI | MENT OF H | EALTH AND DEATH | MENTA | AL HYGIEI | | | |
|---------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------|------------------------------|-----------------------------------------------------|------------|--------------------------------|-------------------|-------------|--------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | Lorr | | | · · · · · · | 2. DAT | E OF DEATH | å å | 3. | TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER 360-09-1452 | 5. SEX 6. AGE (In yr. | 840 | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | OF BIRTH | 12 | 131 | CE (State or Foreign |
| 3 should | E E | Sa. FACILITY NAME (If not institution, give str | | 91 | COLUMN C | OR LOCATION OF D | EATH | 1001 | Sc. COUNTY | | |
| physician. burial-transit permit. Pages 1. 2, | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10 / (1) / (10) | | TOWN OR LOCAT | TION | YK | | 1190 | | I. INSIDE CITY |
| amit. Pa | | 10e. STREET AND NUMBER | Ntgomery | Ca | vret | ZIP CODE | VK | | 10- CITIZE | 1 | VES 2 NO |
| tian. | FUNERAL | 11026 Ker | 11 WOYTH | Ne | , | 2089 | 4 | | 4 | 1.5. | |
| the hospital or attending physician, detached for use as the burial-trainonce. | BY FU | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | ⊠ NO | 13. WAS DEC | ENDENT OF HISPA nelfy Ouben, Mexic 2 NO Speci | an, Puerto | N? (Specify Yo Rican, etc.) | ns or No 14 | Specify: | American Indian, hite, etc. |
| or attending ir use as the | ETED | 15. DECEDENT'S EDUC. (Specify only highest grade of | completed) | Give kind of work | done during mos | ON st of working | | | ISINESS/INDUS | | |
| the hospital of detached for once. | COMPLI | -12- | College (1-4 or 5+) | Music | ian | | | BC PH | | RCH. | |
| d by the de de dat on | ш | Samuel Lichtens | stein | | | Bincha | | | | | |
| s retained to 5 should notified | TO B | Dayid B. | Lorr | BOY | DRESS (Street a | nd Number or Rural | Plaute Nun | nber, City or To | vn, State, Zip Co | (de) | Consent |
| hours after death. Page 6 may be retained by the funeral director, page 5 should be or removal. medical examiner must be notified at | | 20e. METHOD OF DISPOSITION 1 | cemeter) | ACE AND DATE OF D | place) | | DAT | 1.1 | OCATION - CH | | Fart Me |
| death. Page 6 m funeral director. I. examiner musi | | 21. SIGNATURE OF FUNERAL, SHIVICE LICE | | ropoli | 22. NAME AN | cemator D ADDRESS OF FA | CILITY | a. 208 | | | |
| rs after death. P n by the funeral removal. | | 35. PART I. Enter the diseases, or co | Manager that coursed the | doub Dougl | FALLS | CHURC | н. з | MA. | 22046 | | |
| the lion | | MANEDIATE CALICE PIL-1 | ist only one cause on each | iine. | | | | | | | Approximate interval Between Onset and Death |
| executed within and completely o burial, cremati matic event, t | | resulting-in-death) a. | Arterie Due TO (OR AS A CO) Sejere M | NSEQUENCE OF); | " (| | VOLI | 1/15 | ease | | 10 1KS. |
| and o bur | ATION | If eny, leeding to immediate | DUE TO (OR AS A COM | NSEQUENCE OF): | nter | X a | e un e | entia | | | 1710. |
| Phys Debys | CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A COR | NSEQUENCE OF): | | | | | | | |
| 0 6 | | resulting in death) LAST | | | | | | | | | |
| 50 5 | DICAL | PART II. Other eignificent conditions | contributing to deeth but n | ot resulting in t | he underlying | cause given in | Part i. | 24a. WAS AF PERFO 1 YES | RMED? | CON | RE AUTOPSY FINDINGS ILABLE PRIOR TO ILABLE PRIOR TO CAUSE |
| SICIAN: The law requires that certificate has been signed by the State Bept. of Health ar I, or item 23 shows any | I: MEDIC | DID TOBACCO USE CONTR | IBLITE TO CAUSE OF D | FATH YES | □ NO-S | UNCERTAI | | | ~ | | DEATH? YES 2 NO |
| d: The law cate has I State Dept item 23 | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. F HOSPITAL: | PLACE OF DEATH (| Check only one) THER: | ./ | | | | | |
| PHYSICIAN this certifi with the ? | PHYS | 27 MANNER OF DEATH | 1 Inpatient 2 ER/Outpatien 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF | | JRY AT | | | INJURY OCCUP | IED | |
| VDING PHYS : After this r death with is marked | D BY | 1 Naturel 5 Pending Investigation 3 Suicide 6 Could not be | 28s. PLACE OF INJURY — A | | M 1 🗆 Y | ES 2 NO | 28f. LOC | CATION (Street | end Number or | Rural Route | Number |
| OR ATTENDING DIRECTOR: After hours after death item 28 is ma | ETE | 4 Homicide determined | building, etc. (Specify) | | | | City | or Town, State | , | | |
| 4 7 2 m | COMPL | (Check only CERTIFYING PHYSICI | AN: To the best of my knowledge On the basis of examination and | | | | | | | ause(e) enc | f manner se stated. |
| TO THE HOSPIT TO THE FUNERA De filed within 7 | O BE | 296. AGNATURE AND TITLE OF CERTIFIER | Stornerow | | MA | D23 | 188 | | 29d. DATE S | S I | 9/95 |
| | | M. NAME AND ADDRESS OF PERSON WHO 11026 Kenilwort | h Ave. Garr | ett Pa | | 20896 | (L | ouise | M. S | tomi | erowski) |
| | | 31. DATE FILED (Month, Day, Year) AUG 23 1995 | Julia Danulear | Robble | | | | _ | | | |



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.

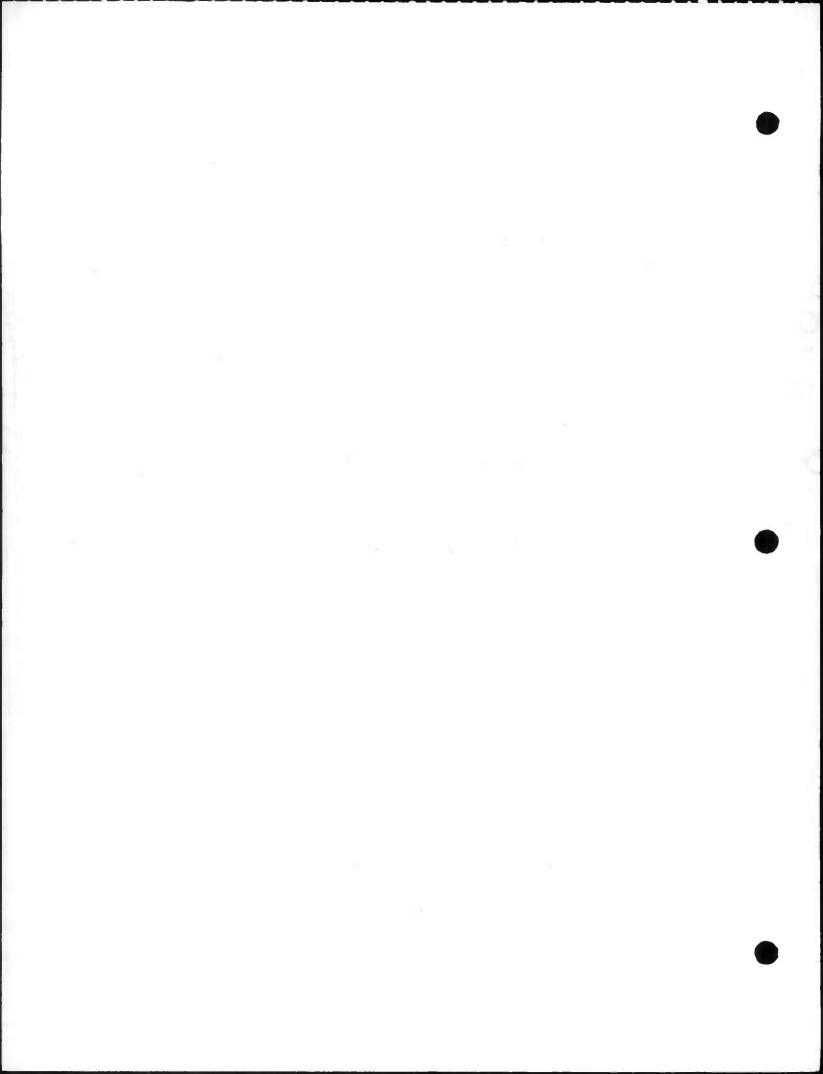
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | ICATE O | F DEATH | REG. N | 0. | | | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|------------------------|----------------------------------|---------------------------------------------|--------------------------------|-----------------|-------------------|-----------------------------------------|--------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | | | 3. TIME OF DEATN | | | |
| | Bernard Shelby Lewis | 3 | | | | August 2 | DAY 100 | YEAR | 4:30 | ам | | |
| | 4. SOCIAL SECURITY NUMBER 5. SE | | In yrs. last birthday) | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7. DATE OF BIRTH | . 2 و 2 . | | PLACE (State or Forei | | | |
| | 578-34-5683 | Ma De | 66 YRS. | MONTHS DAY | | (Month, Day, Year) May 2, 1 | 929 | Country, | ington, I | | | |
| | 9e. FACILITY NAME (If not institution, give street and | i number) | | 9b. CITY, TOW | N OR LOCATION OF DI | | | TY OF DE | | | | |
| DIRECTOR | 19431 Transhire Road | <u> </u> | | Gai | thersburg | <u> </u> | Mon | tgom | ery | | | |
| Ä | 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LO | CATION | | | | 10d. INSIDE CITY | | | |
| <u>a</u> | Maryland Montgome | ry | Gai | thersb | ırg | | | | LIMITS? 1 YES 2 X NO | 0 | | |
| A | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZ | EN OF W | HAT COUNTRY? | | | |
| FUNERAL | 19431 Transhire Road | <u> </u> | | | 20879 | | Uni | ted | States | | | |
| 5 | 1 5 | AS DECEDENT EVER IN PRCES? 1 🔀 YES | | | ECENDENT OF NISPAI specify Cuban, Mexico | | fes or No- | 14. RACE Black | - American Indian, White, etc. | | | |
| BY | | YES, GIVE WAR OR DA | | | ES 2 NO Specif | | | Specify | | | | |
| 8 | 15. DECEDENT'S EDUCATION | | 18e. DECEDENT'S | USUAL OCCUP | TION | 16b, KIND OF E | USINESS/INOI | USTRY | WIIICC | _ | | |
| <u>u</u> | (Specify only highest grade completed in the secondary (0-12) Collection (0-12) | ge (1-4 or 5+) | (Give kind of a | work done during se retired.) | most of working | | | | | | | |
| COMPLETED | | 4 | Printer | 2 | | Self | Employ | ed | | | | |
| Š | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S NA | ME (First, Middle, Maid | en Sumame) | | | | | |
| BE | Otha R. Lewis | | | | Agnes | Bryant | | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | AOORESS (Stre | et and Number or Rural | | own, State, Zip | Code) | | | | |
| 2 | Margaret Lewis | | 19431 | Transh | ire Road, | Gaithers | burg, | MD 2 | 0879 | | | |
| | 20e. METNOD OF DISPOSITION 1 □ Burlel 2 1 Cremetion 3 □ Removal from | 20b | PLACEANDDATE | OF DISPOSITION | (Name of | OATE 20c. | OCATION — C | Ity or Tow | rn, State | | | |
| | 4 Donation 5 Other (Specify) | M M | etropoli | tan Cr | ematory \$ | 195/95 A | exand | ria, | Virginia | a | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSES | 10.0 | 1 | 22. NAME | AND ADDRESS OF FA | CILITY DeVol | Funer | al H | ome | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or compile | cations thet caused | the death. Do r | not enter the | node of dying, auc | h aa cardlac or rea | piratory arre | ent, | Approximate | | | |
| | shock, or heert fellure. Liet only one ceuee on eech line. IMMEDIATE CAUSE (Finel Cleaner or condition | | | | | | | | | | | |
| | | METINSTATIC | CANCIL | on A W | MCHUNN P | Chany | site. | | 220 | | | |
| | disease or condition - METASTATU CANGILLONA WKAUNA Primary Site 2 OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Z | Sequentially list conditions, | | | | | | | | | | | |
| Ĕ | If any, leading to immediate | OUE TO (OR AS A | CONSEQUENCE OF | F): | | | | | | | | |
| 3 | CAUSE (Disease or Injury | OUE TO OR AR A | 2011250115125 | | | | | | - | | | |
| Ë | thet initiated events resulting in death) LAST | OUE TO OH AS A | CONSEQUENCE OF | -): | | | | | | - 1 | | |
| CERTIFICATION | d | | | | | | | | + | - | | |
| | PART II. Other algnificent conditions cont | ributing to deeth b | ut not resulting | n the underly | ing ceuse given in | | N AUTOPSY | | WERE AUTOPSY FIND | | | |
| DICAL | | | | | | 1 YES | DRMED? | | AVAILABLE PRIOR TO COMPLETION OF CAU | | | |
| ME | | | | | | | | 1 | OF DEATH? | | | |
| - | DID TOBACCO USE CONTRIBUT | E TO CAUSE O | F DEATH YE | S 🗆 NO | UNCERTAIL | <u> </u> | | | | | | |
| Ĭ. | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEAT | | | | _ | | | | | |
| PHYSICIAN: | 11103 | PtTAL: patient 2 - ER/Outp | atient 3 DOA | OTHER: | ome 5 K Residence | 6 Other (Specify) | | | | | | |
| ᅔᅵ | 27. MANNER OF DEATH 2 | 8e. OATE OF INJURY (Month, Day, Year) | 28b. TIM | | NJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCC | UREO | | \neg | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (MONIN, Day, 16ar) | 1113 | | YES 2 NO | | | | | | | |
| - 14 | | Se. PLACE OF INJURY building, etc. (Spec | — At home, tarm, a | treet, factory, o | fice | 281. LOCATION (Street | | or Rural Ro | ute Number, | | | |
| COMPLETED | 4 Homicide determined | , , , , , , , , , , , , , , , , , , , , | , | | | City or Town, Sta | 10) | | | | | |
| | 29a. CERTIFIER (Check only 1 🖾 CERTIFYING PHYSICIAN: To | the best of my knowl | edga, death occurre | ed at the time, d | eta end pieca, and dua | to the ceuse(e) and n | enner as state | d. | | | | |
| N N | one) 2 MEDICAL EXAMINER: On the | | | | | | | | end manner as state | ed. | | |
| | 29h. SIGNATURS AND TITLE OF CENTIFER | | | 300 1.0 | 29c. LICENSE NUI | | _ | | | | | |
| BE | h)/m/ok | mi | | | DY96 | - | DATE | JOHED (| Mgoth, Day, Year) | | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO COMP | PLETED CAUSE OF DEA | ATH (ITEM 27) (Torse | Print) | 1 22/0 | /) | 0 | 27/4: |) | - | | |
| | KAUPIT V. BACC | In hat | | | GR R | H2 - | 2004 | , N. | | | | |
| | 31. DATE FILED (MANTH) Cay. 2.3 1995 3 | 2. REGISTRAR'S SIGN | TURE - | DIVIN | CILK | 11 500 | rouch | 114 | | - | | |
| | 700.78 1995 | Julia davels | or Randall | | | | | | | | | |



DHMH-18 Rev 1/89

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

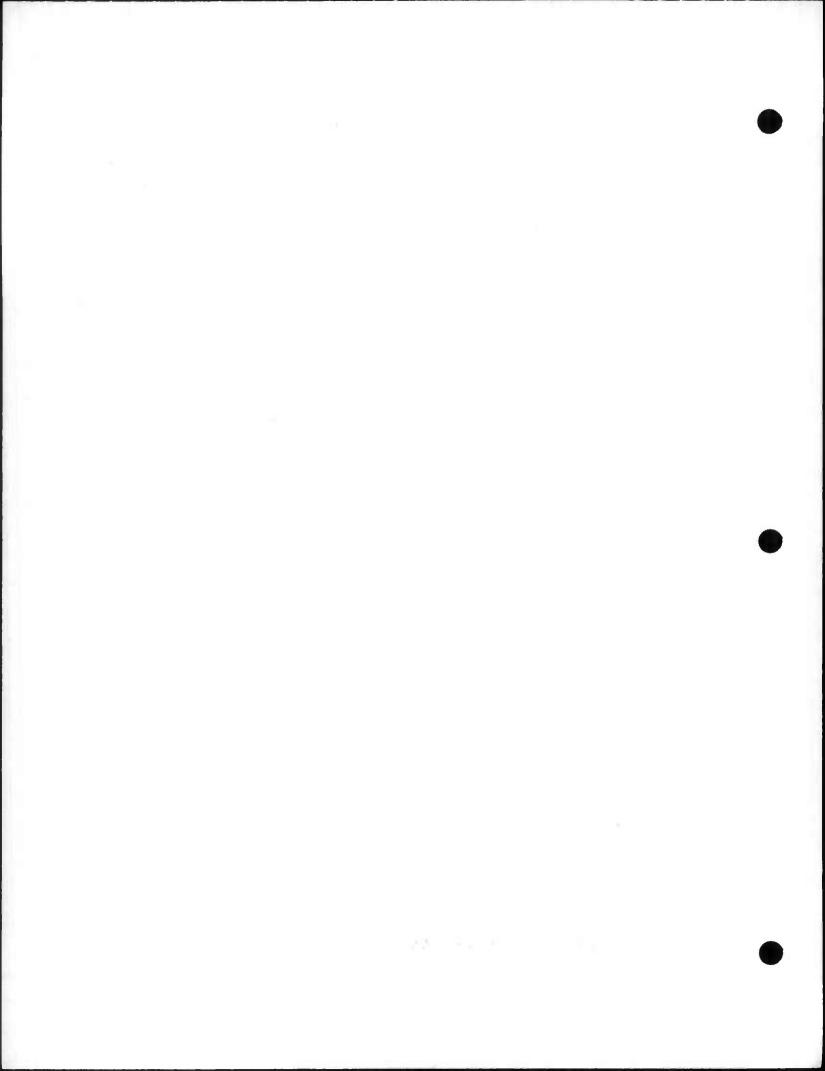
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | nediothan | | - CL | -11111 | CALL | - 01 | DEAL | | HE | NO. | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------|--------------|--------------|----------------|---------------|--------------------|---------------------------------------------|-----------------------|-------------|-------------------------------------|-------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | | | 2. DATE OF DE | ATH DA | NY. | YEAR | 3. TIME OF DEATH |
| | CURTIS 4. SOCIAL SECURITY NUMBER | 1 | | MARSHALL | | | | | HUGUST | 20 | 0/ | 995 | 3:30 pm |
| | ALVANIA STATE | | 8. AGE (In yrs. les | | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 7. DAYE OF BIF (Month, Day, OCT • 9 , | TH Mar) | | 8. BIRTH Countr | PLACE (State or ForeignD |
| | 577-24-8342 | 1 📉 M 2 🗆 F | 82 | YRS. | | | | | | 191 | | R MARLBORO, | |
| ا <u>س</u> ا | 9a. FACILITY NAME (If not institution, give WELLINGTON N | | | | | OR LOCATIO | ON OF DE | ATH | | | NTY OF D | | |
| 2 | RESIDENCE OF DECEDENT | MANOR | | | | LIN | LOW | | | | PRII | VCE G | EORGE'S |
| DIRECTOR | 10e. STATE 10b. COUNT | TY | | 10c. CIT | Y, TOWN C | R LOCAT | rion | | | | | | 10d. INSIDE CITY |
| ā | MARYLAND PRING | CE GEORGE | S | | CLI | NTO | V | | | | | | LIMITS? |
| AL | 10e, STREET AND NUMBER | | | | 101 | . ZIP CODE | E | | | 10g. CIT | IZEN OF W | /HAT COUNTRY? | |
| 띨 | 9211 STUART LAN | E | | | | | 20 | 735 | | | US | SA | |
| FUNERAL | 11. MARITAL STATUS | EVER IN U.S. ARI | MED | | | | | IC ORIGIN? (Spe | | or No- | 14. RACE | - American Indian, , White, stc. | |
| BY | 1 Never Married 2 Merried 3 X Widowed 4 Divorced | IF YES, GIVE WAI | R OR DATES | | | | 2 XNO | | | rec.) | | Speci | Ar. |
| ED | 15. DECEDENT'S EDI | ICATION | I the DE | CEDENTIC | USUAL OC | CHIDATI | 201 | | T | | | | BLACK |
| | (Specify only highest grad Elementary/Secondery (0-12) | le completed) | (G/ | ve kind of a | work done o | during mo | st of workin | g | 16b, KIND | | | | |
| 7 | 9th | College (1-4 or 5 +) | CUS | TODI | AN | | | | P.G. | JOOT | UNIT' | (GOV | ERNMENT |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTH | IER'S NAM | AE (First, Middle, | - | _ | II(D) | | |
| BE C | JAMES A. MARSHAI | LL | | | | - 1 | | | A JONES | | , | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19t | . MAILING | ADDRESS | (Street e | nd Number | or Rural A | oute Number, City | or Town | , State, Zi | Code) | |
| 임 | MARY J. NEWMAN/ 1 | DAUGHTER | 12 | 23 S | ANDA | LWO | DD RO | AD H | ARWOOD | MA | RYL | AND | 20776 |
| | 20a. METHOD OF DISPOSITION 12 Burlet 2 Cremation 3 Ren | noval from State | 20b. PLACE A | NDDATE | OF DISPOS | | | | 1 | | | City or To- | wn, State |
| | 4 Donation 5 Other (Specify) | | RESUR | RECT | | | | | | LIN | TON, | MAR | YLAND |
| ! | 21. SIGNATURE OF FUNERAL SERVICE LI | ICENSEE/ | 101/ | 4 | | | O AOORES | | | > T T > T |) A T | TIOM | |
| | Juawara A. Olakton 7474 Landover Road Landover, MD20785 | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | Approximate |
| | IMMEDIATE CAUSE (Final Onest and Das | | | | | | | | | | | | |
| | disease or condition resulting in death) | | | | | | | | | | | 24/20 | |
| | Due TO on As a consequence of: | | | | | | | | | | | 12 1101 | |
| Z | Several de la contra de mentia | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate DUE TO YOR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | | | | | | | | | | | | |
| E | that initiated events resulting in death) LAST | | | | | | | | | | | ì | |
| S | | d | | | | | | | | | | | 1 |
| | PART II. Other aignificant condition | ne contributing to de | eeth but not re | eaulting i | n the un | derlying | ceuse g | iven in F | Part I, 24a. V | AS AN A | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | | | ERFORI YES 2 | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| ME | | | | | | | | | | | | | OF DEATH? 1 YES 2 NO |
| | DID TOBACCO USE CONT | RIBUTE TO CAU | SE OF DEAT | TH YE | S 🗆 N | 10 E | UNC | ERTAIN | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERED TO MEDICAL EXAMINER? | HOSPITAL: | 28. PLAC | E OF DEAT | H (Check o | | | | | | | | |
| YSI | 1 YES 2 TO NO | 1 Inpatient 2 E | ER/Outpatient 3 | □ DOA | 4 M Nurs | | e 5 🗆 Res | sidence 6 | Other (Speci | (y) | | | |
| H | 27. MANNER OF DEATH | 28e, DATE OF IN (Month, Day, | JURY Year) | 28b. TIM | E OF URY | 28c. INJ WO | URY AT RK? | | 28d, DESCRIBE | HOW IN | JURY OC | CURED | |
| B | 1 M Natural 5 Pending 2 Accident Investigation | | | | М | 1 🗆 1 | | NO NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF I | INJURY — At hor c. (Specify) | ne, farm, a | treet, fecto | ory, office | | | 28t. LOCATION (City or Town | Street er State) | nd Number | or Rural R | oute Number, |
| E . | | | | | | | | | | | | | |
| 릴 | 29e. CERTIFIER (Check only one) | | | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMIN | ER: On the basis of exar | mination end/or in | rvestigatio | n, In my o | pinion, d | eath occur | ed at the t | ime, date and plo | ice, end | due to th | ne ceuse(e) | end menner as stated. |
| ш | 256. SIGNATURE AND TITLE OF CERTIFIE | D. 100 | D / | AA | | | 29c. VCE | NSE NUMB | HER | 7 | 29d. DAT | E SIGNED | Winth, Day, Years |
| 10 B | I work | 1 10/1 | 2 A | lle | vol | 4 | _1) | -2 | 453 | 2 | > | 21 A | ng 1995 |
| - | 30 NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE | OF DEATH (ITEM | 27) (Types | Unio V | 13 | De | inel | Air | 0 | VILLE | +20 | md |
| Į. | Lacini Devi | ua MIL |) . [| 100 | 0 | 101 | DIC | MO | THUE | . (| 111 | HUY | 1,1110 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | | | | | | | | | | | |
| | AUG 23 1995 9 | his d'audion | rardall | | | | | | | | | | |

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| ter death. Page 6 may be retained by the hospital or attending physician. | the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should yad. | al examiner must be notified at once. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | O DE COMDI ETER DV DUVOICIAM, MEDICAL |

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN | | | | | | |
|---------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------|--------------------|-----------------------------------------------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Adolf | | | Miller | | August 23,19 | 995 YEAR | 2:50 A M | | | | |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | B. BIFT | THPLACE (State or Foreign | | | | |
| | 578-05-2289 | 1 XXM 2 □ F 8 | 9 YRS. | MONTHS DAYS | HOURS MIN. | 1-2-1906 | | rmany | | | | |
| · · | 9a. FACILITY NAME (If not institution, give str | | | | R LOCATION OF E | DEATH | Onarles | DEATH | | | | |
| DIRECTOR | Physicians Memorial H | ospital | | La Plata | | | | | | | | |
| SE SE | 10a. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCAT | TON | | | 10d, INSIDE CITY | | | | |
| ä | Maryland Prin | ce George's | | Temple | Hills | | | LIMITS? | | | | |
| ERAL | 10a. STREET AND NUMBER | | | 101. | . ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | |
| Ä | 6425 Allentown Ro | | | | 20748 | | | SA | | | | |
| FUN | 11. MARITAL STATUS 1 Nover Married Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 NO | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specity Yes | or No- 14. RA | CE — American Indian, ck, White, etc. | | | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ITES 11 | 1 TYES | 2 NO Speci | ffy: | Spe | White | | | | |
| 0 | 15. DECEDENT'S EDUC. (Specify only highest grade of | ATION | 16a. DECEDENT'S L | JSUAL OCCUPATIO | ON . | 16b. KIND OF BUS | SINESS/INDUSTRY | wiite | | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | ork done during mos retired.) | st of working | | | | | | | |
| ₩ | 12th | | Meat C | ıtter | | Meat S | Supplier | S | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | 1/122 | | | 18. MOTHER'S N. | AME (First, Middle, Malden | Surname) | | | | | |
| BE | UNKNOWN 19a. INFORMANT'S NAME (Type/Print) | Miller | | | | unknown | | | | | | |
| 2 | William Thomas B | ioog In | | | | Route Number, City or Tow | | | | | | |
| | | | PLACE AND DATE OF | | | LaPlata, | Maryland | | | | | |
| | 20a, METHOD OF DISPOSITION 1/_XBurlal 2 | rel from State carri | elery, cremetary or oth | er place) | me or Q | 25-95 Sui | CATION — City or 1 | fown, State | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | cuar IIII. | 22. NAME AN | ID ADDRESS OF E | ACILITY | | Maryland | | | | |
| 1 | George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | | | | | | | | |
| \vdash | 23. PART I. Entar the diseases, or co | molications that caused | the death Do no | 6160 | Oxon Hi | 11 Rd. Oxor | Hill, 1 | | | | | |
| | shock, or heart failure, L IMMEDIATE CAUSE (Final | iat only one cause on as | ich ilna. | | ua or dying, au | cii as cardiac or reapi | ratory arrest, | Approximate interval Between Onset and Death | | | | |
| | disease or condition resulting in death) | Com | \sim . | | Criset and Death | | | | | | | |
| | | DIE TO (OR AS A | CONSEQUENCE OF | J | | | | | | | | |
| ON | Sequentially list conditions, Due TOYON AS A COMSEQUENCE OF I | | | | | | | | | | | |
| YAT | if any, leading to immediate cause. Enter UNDERLYING | Win | Jul. | } | | | | i | | | | |
| Ē | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | |) | | | 1 | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| | PART II. Other significant conditions | contributing to death by | it not resulting in | the underlying | Cause alvee le | Part I. 24e. WAS AN | aumoney I as | | | | | |
| CAL | | | t not resulting in | the underlying | Cause given in | PERFOR | MED? | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| EDIC | | | | | | 1 _ YES ½ | 700 | OF DEATH? | | | | |
| Σ :: | DID TOBACCO USE CONTR | BUTE TO CAUSE OF | F DEATH YES | ПОП | UNCERTAI | NKI | | 1 YES 2 NO | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 2 | 6. PLACE OF DEATH | | ONCERNA | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | | | | | | |
| Si | EXAMINER? | HOSPITAL: | | OTHER: | 5 Residence | 6 Other (Specify) | | | | | | |
| 됩 | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c, INJL | JRY AT | 28d. DESCRIBE HOW II | NJURY OCCURED | | | | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 Y | ES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28s. LOCATION (Street and Number or Rural Route City or Town, Stefe) | | | | | | | | | | |
| COMPLETED | | | | | | | | | | | | |
| MP | (Check only CERTIFYING PHYSICI | AN: To the best of my knowle | dge, death occurred | at the time, date | and place, and due | s to the cause(a) and man | mer as stated. | | | | | |
| 8 | | On the beals of examination | aridisr Investigation | , in my opinion, de | with occurred at the | time, data and place, an | d due to the cause | (a) and manner as stated. | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | de | | \ | 29c. LICENSE NU | MBER | 29d. DATE SIGNE | D (Month, Day, Year) | | | | |
| 0 | 30 NAME AND ADDRESS OF REPORT WALL | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, PMT) | | | | | | | | | | |
| 1 | George Wather MD, 11345 | | | CONTRACTOR OF THE PARTY OF THE | MH 30403 | | _ | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 412. REGISTRAR'S SIGNA | TURF | - CLICIOLL, | 131. 2000 | | | | | | | |
| | AUG 24 1995 | Jeli otwolork | entell | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIANS The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTORS After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | | | | | | | | | - | J | 21132 |
|---------------|------------------------------------------------------------------|------------------------------|-------------------------------------------|-----------------|---------------------------|----------------|---------------|-------------|-----------------------------------|--------------|-------------|-------------------------------------|
| | FOR STATE REGISTRAR | STATE OF N | | | | | DEAT | | MENTAL HYGIEN | | | |
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF OEATH | | | 3. TIME OF DEATH |
| | Albert U. Max | well | | | | | | | August 12 | 2, 199 | YEAR 95 | 11:25 AM M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | ., 10. | | PLACE (State or Foreign |
| | 579-11-0185 | 1 🕅 M 2 🗆 F | M 2 F 91 YRS. MONTHS DAYS HO | | | | | MIN. | (Month, Day, Year) February 6, |) | | |
| | 9a. FACILITY NAME (If not institution, give st | met and number) | et and number) 9b. CITY, TOWN OR LOCATION | | | | | | | | | aica |
| 00 | | | ** | | | | | ON OF DE | НТА | | NTY OF DE | |
| 0 | Presidential Wood | ds Nursi | ng Home | | 1 | Adel | .phi | | | Prin | ice G | eorge's |
| DIRECTOR | 10a. STATE 10b. COUNTY | , | | I 10c CIT | V TOWN | OBLOCA | HON | | | | | |
| <u>E</u> | INC. CITY, TOWN ON EDGATION | | | | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | 4. ATTEST AND MUNICIPALITY | | | | | | | | | | | 1 X YES 2 ND |
| FUNERAL | | | | | | 101 | . ZIP CODE | | | 10g. CITI | | HAT COUNTRY? |
| 單 | 1801 Metzerot | t Road | | | | | 207 | 83 | | | U | SA |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT O | F HISPAN | IC ORIGIN? (Specify Ye | a or No- | 14. RACE | - American Indian, |
| | 1 Never Married 2 Married | IF YES, GIVE W | | ID | | | ecify Cuba | | n, Puerto Rican, etc.) | | Specify | White, afc. |
| BY | 3X Widowed 4 Divorced | | | | | | - 25 | opeany | | - 1 | Specin | Black |
| | 15. OECEDENT'S EDUC | | 16a. DE | CEDENT'S | USUAL (| CCUPATIO | ON | | 166. KIND OF BU | ISINESS/INC | DUSTRY | |
| <u> </u> | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 a | (G/ | Do NOT us | work done se retired.; | during mo | st of workin | 0 | | | | |
| 4 | , (0.12, | 2 yrs. | | Reve | ren | d | | | Pr | ivat | ce | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 40 44077 | AFR'S MAI | ME (First, Middle, Maider | | | |
| - 1 | Richard Maxwe | 11 | | | | | | | White | i Sumame) | | |
| BE | | 211 | | | | _ | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | oute Number, City or Tov | | | 20721 |
| - | Patricia B. Fingal 10803 Kencrest Drive, Mitchellville, MD 20721 | | | | | | | | | | | |
| 1 | 20a METHOD OF DISPOSITION 1- Surial 2 Cremation 3 Rame | uml form State | 20b. PLACE | ND DATE | OF OISPO | SITION (Na | me of | | PAJE 20c. LC | CATION - | City or Tow | n, State |
| | 4 Donation 5 Other (Specify) | Toni Stata | - Washi | netory or o | ther place | tion | പെ വ | reter | 8/16 20c. LG Y 1995 Su | itlan | d. Ma | ryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE / | /). | | 22 | NAME A | D ADDRES | S OF FAC | CHITY | | | 4 |
| 1 | N III A II A II | A K | PYDAN | la | | | | | s Funeral | | | |
| | - Julianun | aut | 1200 | 1000 | | | | | r Rd., Lar | | | 20785 |
| | 23. PART i. Enter the diseases, or c shock, or heart failure. I | omplications that | coused the de | eth. Do r | not ente | r the mo | de of dyl | ng, suct | ss cerdisc or resp | iratory sn | rest, | Approximats |
| | IMMEDIATE CAUSE (Finsi | List only one ceu | se on esch line. | | _ | | | | | | | Interval Between Onset and Death |
| | disesse or condition | Mel | 7147 | ti | 0 | 10 | 1/2 | 4 - | Lung | , | | 11.00 |
| | resulting in death) | DUE TO | (OR AS A CONSED | HENCE O | CH CH | 10 | 1100) | 19 | Long | | | 19 |
| | | 502.10 | (ON AS A CONSED | DENCE O | r): | | | | | | | |
| CERTIFICATION | Sequentisity list conditions, | h. | | | | | | | | | | |
| Ē | If sny, lesding to immediate | DUE TO | (DR AS A CONSED | UENCE O | F): | | | | | | | } |
| [절] | Cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | |
| 별 | that initiated events | DUE TO | OR AS A CONSEC | WENCE DI | F): | | | | | | | |
| 품 | resulting in deeth) LAST |) | | | | | | | | | | |
| ō | PART II Other cignificant condition | | | | | | | | | | | |
| ₹ | PART ii. Other significent conditions | contributing to | deeth but not re | esulting | in the u | nderlying | g ceuse g | iven in l | Part I. 24s. WAS AN | | | WERE AUTOPSY FINDINGS |
| MEDICA | 17/ Werner | 1) () che | ref. | | | | | | 1 YES : | NO | | COMPLETION OF CAUSE OF DEATH? |
| 핕 | Braberes n | relli To | scin | sul | m T | len | ende | us 1 | | 7. | | YES 2 NO |
| 1.0 | DID TOBACCO USE CONTR | BUTE TO CA | USE OF DEAT | TH YE | SП | NO F | LINC | ERTAIN | | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL | | | E OF DEAT | | | 0140 | FKIMI | | | | |
| $\frac{1}{2}$ | EXAMINER? | HOSPITAL: | | T | QTHE | | | | | | | |
| ₹ | 1 TYES 2 NO | 1 Inpatient 2 | | | - | | | aldence (| 6 Other (Specify) | | | |
| 표 | 27. MANNER OF OEATH 1 Natural 5 Pending | 28a. DATE OF (Month, De | | 28b. TIM INJ | E OF URY | 28c, INJ WO | URY AT RK? | | 28d. OESCRIBE HOW | INJURY OCC | CURED | |
| B≼ | 1 Natural 5 Pending 2 Accident Investigation | 1 | 1/1 | | M | 1 🗆 1 | rES 2 | NO | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE Di | INJURY - At hor | na, farm, c | street, fac | tory, offic | | | 28f. LOCATION (Street | | or Aural Ro | ute Number, |
| ш | 4 Homicide datarmined | ounding, | etc. (Opecny) | | | | | | City or Town, State, |) | | |
| 4 | 29a. CERTIFIER | NAME TO SECOND | | | | | | | | | AT 1 | |
| ₽ | (Check only | | | | | | | | to the cause(a) and ma | | | |
| COMPLET | 2 MEDICAL EXAMINER | the basis of a | amination and/or is | nvestigatio | n, in my | opinion, d | eath occur | ed at the t | fime, data and placa, ar | nd due to th | e cause(s) | and manner as stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | 1011. | 0 | | | | 29E-LICE | NSE NUM | BER | | | Month, Day, Year) |
| 8 | & Bullen | m we | | | | | 1 | 07/5 | 252 | | 15 | -95 |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO | Onen even | | | _ | | ~ ~ | -10 | 0 - | | (3 | / 0 |



31. DATE FILED (Month, Day, Year) AUG 21 1995

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

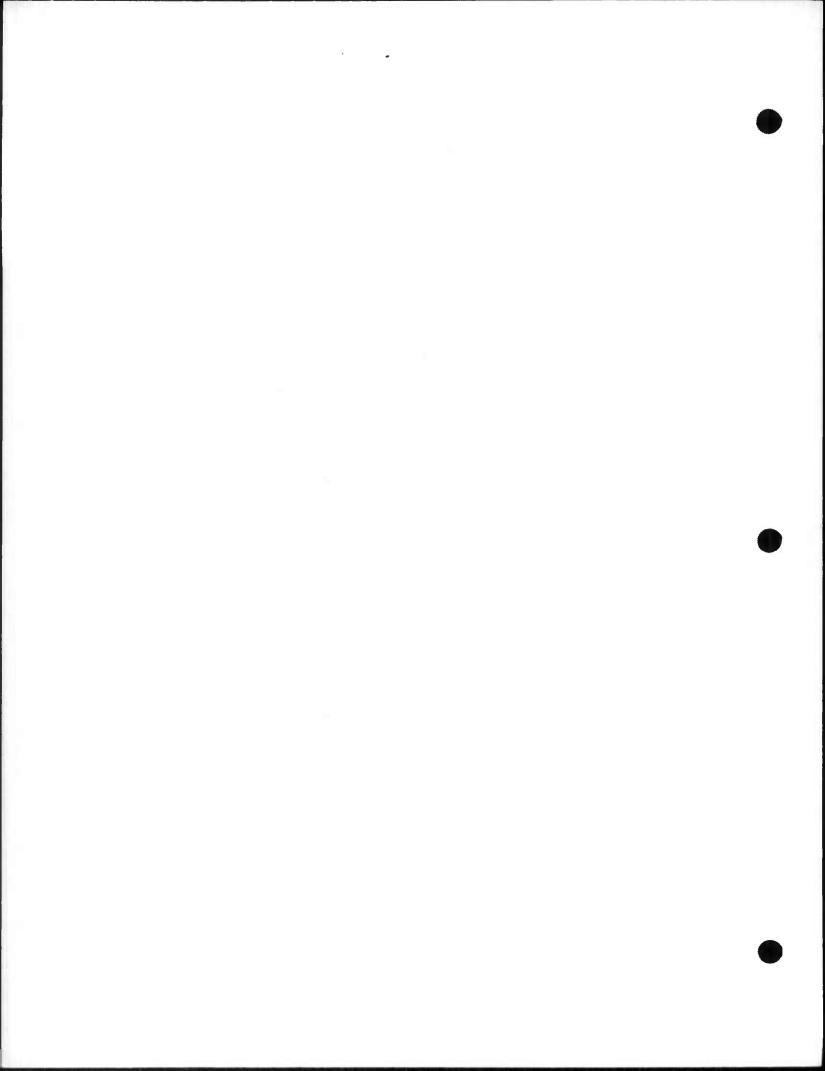
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN! The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | * REGISTRAR | | CI | ERTIF | CATE O | F DEATH | | REG. NO. | | | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------|-------------------|--------------------------|---------------------|----------------------|-----------------------------|-----------------|------------|----------------|---------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | - | | 2. DATE | OF DEATH | | YEAR : | 3. TIME OF DE | ATH |
| | | JOHN | McCLE | | | | AUG. | | 1995 | TEAN. | 4:00 | AM M |
| | 4. SOCIAL SECURITY NUMBER | | 3. AGE (In yrs. les | F | IF UNDER 1 YEAR | | 7. DATE ((Month) | OF BIRTH , Day Year) | | | LACE (State or | |
| | 040-64-6668 | 1 🔀 M 2 🗆 F | 31 | YRS, | | | | 5, 1 | 963 | MISS | SOURI | |
| OC. | 9s. FACILITY NAME (If not institution, give a | | | | | OR LOCATION OF | DEATH | | 9c, COUNT | | | |
| DIRECTOR | 13 PAPERMILL S | TREET | | | EA | STON | | | T | ALB(| OT | |
| EC | 10a. STATE 10b. COUNT | r | | 10c. CITY | , TOWN OR LOC | ATION | | | | | IOd. INSIDE CI | TY |
| 딤 | MARYLAND TAI | BOT | | | EAST | ON | | | | 1 | X YES 2 | |
| AL | 10e. STREET AND NUMBER | | | | | of, ZIP CODE | | | 10g. CITIZE | | IAT COUNTRY | |
| ER | 13 PAPERMILL S | STREET | | | | 21601 | | | U | SA | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. AR | MED | 13. WAS DI | CENDENT OF HISP | ANIC ORIGIN | ? (Specify Yes | or No- 1 | 4. RACE - | - American In | dlen, |
| BY | 1 Never Merried 2 Merried 5 Merried 5 Merried 6 Merried 7 Merried 7 Merried 7 Merried 8 Merried 8 Merried 8 Merried 8 Merried 8 Merried 8 Merried 9 Merried | | | | | | | | | | | 12 |
| | | | | | | | WHIT | E . | | | | |
| I | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| 7 | 12 College (1-4 or 5+) LAWYER T.E.GAT. FT | | | | | | | | | | | |
| COMPLETED | India in | | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surmame) RUTH C. SPEH | | | | | | | | | | | |
| 38 C | 19a. INFORMANT'S NAME (Type/Print) | | 198 | . MAILINO | ADDRESS (Street | and Number or Rura | | | t, State, Zip C | (ode) | | |
| 2 | REV.DONALD J. | McCLEAN | | | | LL STRE | | | | | 1601 | |
| | 20e. METHOD OF DISPOSITION | | 20b. PLACE | ND DATE O | F DISPOSITION (| Varne of | OATE | | | | | |
| | 4 Donation 5 Other (Specify) SALISBURY CREMATORY 8-21 SALISBURY, MD | | | | | | | | | | | |
| | 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. 23. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 2160 | | | | | | | | | | | |
| | PETERN > | DE CALE | 207 0 | C 2 | NEWIN | C HYDD | TCOM | cm | P.A | · MON | MD | 2160 |
| | 23. PART I. Enter the diseases, or o | complications that o | caused the de | eth. Do n | ot enter the m | ode of dylng, su | ch as card | ac or respi | ratory arres | LON | Approxi | |
| | shock, or heart feliure. IMMEDIATE CAUSE (Finel | List only one ceuse | on each line | | | | | | | | Interval | Between nd Death |
| | disease or condition - e. Aids - //yer | | | | | | | | | | | rear |
| | | | | | | | | | | | | |
| Z | Sequentielly list conditions, The Chapter Cale Cale Cale Cale Cale Cale Cale Cale | | | | | | | | | | | |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause, Enter UNDERLYING | | | | | | | | | | | |
| 5 | CAUSE (Disease or Injury | | | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | | | | | | | | | | | |
| S | | | | | | | | | | | | |
| | PART II. Other aignificent condition | s contributing to de | eath but not n | naulting i | n the underlyl | ng cause given i | n Part I. | 24s. WAS AN . PERFOR | | | VERE AUTOPSY | |
| EDICAL | | | | | | | | 1 YES 2 | | 0 | OMPLETION OF | |
| ME | | | | | | | | | | | YES - | NO |
| | DID TOBACCO USE CONTI | RIBUTE TO CAU | SE OF DEA | TH YE | S INO | UNCERTA | IN 🗆 | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | E OF DEAT | H (Check only one |) | | | | | | |
| YSI | 1 YES 2 110 | 1 Inpatient 2 E | R/Outpatient 3 | □ DOA | OTHER: 4 - Nursing Ho | me -07 Residence | 6 Other | (Specify) | | | | |
| H. | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF IN (Month, Day, | | 28b. TIME INJU | | JURY AT ORK? | 28d. DESC | CAIBE HOW IN | JURY OCCU | RED | | |
| BY | 2 Accident Investigation | | | | | YES 2 NO | | | | | | |
| 9 | 3 Suictide 6 Could not be 4 Homicide determined | 28e. PLACE OF I | NJURY — At hou c. (Specify) | me, ferm, a | treet, factory, off | ca | 281. LOCA City of | TION (Street a Town, State) | nd Number or | Rural Rou | ite Number, | |
| ET | | | | | | | | | | | | |
| 릴 | | CIAN: To the best of m | | | | | | | | | | |
| COMPLET | 2 MEDICAL EXAMINE | R: On the beals of exam | nination and/or I | nvestigation | , in my opinion, | death occured at th | ne time, deta e | and place, and | due to the | cause(a) a | ind menner se | stated. |
| шШ | 296. INCHATURE AND TITLE OF CERTIFIED 29d. DATE SIGNED (Month) Day, Year) | | | | | | | | | | | |
| 8 | July Nasherkin, 41) D31108 > 8/21/55 | | | | | | | | | | | |
| 9 11 | 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 5 | 30. NAME AND ADDRESS/OF PERSON WHO | COMPLETED CAUSE | OF SEATH LITER | 27) (type, | Print) | 0 | 1 | 0 | | 1 | | , - |
| 1 | 30. NAME AND ADDRESS OF PERSON WHO | Shinton | OF BEATH (ITEN | 27 (MPO). | BLAN | , Stre | do | emp | rida | 1 | 1D 21 | 16/3 |



| D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TOR: A | flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL | TO THE FUNERAL DIREC | be filed within 72 | IMPORTANT: If |

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

| | 1. DECEDENT'S NAME (First, CHRISTOP) | | | | MA | ACKA | LL | | | 2. DATE OF DE MONTH AUGUST | DAY 15 | 1995 | 3. TIME OF DEA | ATH P M |
|-----------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------|---------------------------------------|--------------|--------------|----------------|----------------------|---------|----------------------------------|---------------|---------------|---------------------------------|---------------------|
| | 4. SOCIAL SECURITY NUME 579-82-15 | | 5. SEX | 6. AGE (In yrs. les | ,,, | IF UNDER | t YEAR DAYB | IF UNDER 24 I | _ | 7. DATE OF BIR | RTH (Next) | 8. BIRT | HPLACE (Stete or I | Foreign |
| | Se. FACILITY NAME (If not in | stitution, give s | 112 | | | 9b. CITY | TOWN (| OR LOCATION | OF DE | | | COUNTY OF | | Ly |
| DIRECTOR | PRINCE G | EORGE | | TAL | | | | ERLY | | | | | E GEOR | RGES |
| EC | 10e. STATE | 10b. COUNT | γ | | 10c. CI1 | Y, TOWN | OR LOCAT | TION | | | | | 10d. INSIDE CIT | ry |
| H | Maryland | Prin | ce Geor | ge's | Mo | orni | nas | ide | | | | | LIMITS? | NO |
| 7 | 10e. STREET AND NUMBER | | | | | | | . ZIP CODE | | | 10 | g. CITIZEN OF | WHAT COUNTRY? | |
| ER/ | 6106 Elme | ndorf | t Drive | | | | | 2074 | 6 | | 1 | Initod | State | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDE | NT EVER IN U.S. AF | MED | | | ENDENT OF H | IISPANI | IC ORIGIN? (Spe | city Yes or N | lo- 14, RAG | E - American Inc | |
| | 1 Never Married 2 | | IF YES, GIVE | MAR OR DATES | NO | | | ecify Cuban, fi | | , Puerto Rican, | etc.) | Spe | ck, White, etc. | |
| ВУ | 3 Widowed 4 Divo | erced . | | | | | | Λ- | | Black | | | Black | < |
| COMPLETED | | EDENT'S EDU y highest grade | | (0 | live kind of | Work done | during mo | ON ost of working | | 16b. KIND | OF BUSINES | SS/INDUSTRY | | |
| | Elementary/Secondary (0 | 0-12) | College (1-4 or 5 | +) Hila | . Do NOT u | se retired.) | | | | | | | | 1, 1 |
| MP | 10th | | | I | awn | Car | re | | | | Priva | | | |
| 8 | 17. FATHER'S NAME (First, M | | 5 30 1 | | | | | 16. MOTHER | R'S NAN | WE (First, Middle, | Meiden Sum | eme) | | |
| BE | Daniel W | | ckall | | | | | | | Smit | | | | |
| 10 | Nora Jac | | Mother | | | | | | | oute Number, City | | | MD 20 | 746 |
| | 20e, METHOD OF DISPOSIT | | | 20b. PLACE | | | | eme of | | DATE | 20c. LOCATI | ON — City or | lown, Stata | |
| | 4 Donation 5 Other | (Specify) | | - Harn | | | | rv | | 8/21 | Land | dover | MD. | |
| | 21. SIGNATURE OF LUMERA | L SERVICE LI | CENTER | 1 | | | | ND ADDRESS | | YILITY | | | 207/ | 13 |
| | 1 | - 5 | A | / | | A 2 | 11a | ntis 69th. | Lo | ng Fu | neral eat | l Ser | vices ant. MI | D |
| | 23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | neart fallure. | e. Gun | use on each line | 0. | | | | | | | | Onset at | Batwean nd Daath |
| MEDICAL CERTIFICATION | Sequentially list condit if any, leading to imme | diate | b | O (OR AS A CONSE | OUENCE (| OF): | | | | | | | | |
| FICA | cause. Enter UNDERLY CAUSE (Disease or inju- that initiated eventa | | cDUE TO | O (OR AS A CONSE | QUENCE (| DF): | | | | | | | | |
| E | resulting in death) LAS | T | d | | | | | | | | | | | |
| 2 | PART ii. Other aignifica | ant condition | no nontribution t | a double hout mat | | In Alexander | - d - d. d. | | | Deat Law | WAS AN AUT | maay I a | Ib. WERE AUTOPSY | |
| X | PART II. Other aignities | int condition | na contributing t | o death but not | reauting | in the u | nderiyin | d canse dia | en in i | | PERFORME | | AVAILABLE PRIO COMPLETION OF | OR TO |
| ă | | | | | | | | | _ | - 108 | YES 2 | NO | OF DEATH? | - CAUSE |
| ME | | | | | | | | | | | | | 1 YES 2 | NO [|
| ä | DID TOBACCO U | | RIBUTE TO CA | | | | | | RTAIN | 1 📗 | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED T EXAMINER? | TO MEDICAL | HOSPITAL: | 26. PLA | CE OF DE | OTHE | | | | | | | | |
| YS | 1 XYES 2 NO | | | ☐ ER/Outpatient | - | 4 🗆 Nu | rsing Hor | | dence | 6 Other (Spec | | | | |
| H | 27. MANNER OF DEATH 1 Netural 5 | Pending | 26a. DATE C (Month, | FINJURY Day, Year) | | JURY | W | JURY AT ORK? | | 28d. DESCRIBE | E HOW INJU | RY OCCURED | | |
| BY | 2 Accident | Investigation | 8/15 | 195 | 10 | -4 | 1 | V | NO | 3 461 | Ret | s hus | | |
| | 3 Sulcide 6 4 | Could not be determined | building | OF INJURY — At h j, etc. (Specify) | | | | 1 | | City or fow | in, State) 5 | 284 Ma | estenson | o ke |
| E | | | | Su | ymn | ny | poo | / | | Corps 78/ | Hera | Up, AL | (| |
| COMPLETED | one) | | ER: On the basic of | | | | | | | | | | e(s) and manner as | a etated. |
| BE C | 29b. SIGNATURE AND TITL | E OF CERTIFIE | ER | 101 | , | | | 29c. LICENS | | | | | ED (Month, Day, You ST 16, 1 | |
| 6 | 30. NAME AND ADDRESS O | 1 ren | m) | luv | to un | | | 0.0 | | | | | | |
| | Dennis | 3. | Chote | 1 | | | St | reet | , в | Baltim | ore, | Mary | land 2 | 1201 |
| | 31. DATE FILED (Month, Day, AUG 2 | 3 1995 | | AAR'S SIGNATURE | arbell | | | | | | | | | |

Dark marketing (1800)

BE COMPLETED BY FUNERAL DIRECTOR

2

| IDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2. 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ted, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fut be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traum | |

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

5 Pending Investigat

1 YES 2 NO

27. MANNER OF DEATH

1 Natural 5

2 Accident

| | | | | | - | | • | | | | 9 | 5 | 27136 |
|-----------------------------------------------------------------|---------------|------------------------------------------------|-------------------|--------------|-----------------|----------------|--------------|--------------|------------|-----------------------------------------------|-----------|-----------------------------|-----------------------------------|
| FOR STATE REGISTRAR | | STATE OF M | MARYL | AND / | DEPAR ERTIF | RTMEN | T OF H | EALTH DEA | AND I | MENTAL HYGIEI | | | |
| 1. DECEDENT'S NAME (First, M | liddle, Last) | | _ | | | | | | | 2. DATE OF DEATH | | -50 | 3. TIME OF DEATH |
| Lucille | 8- | Mir | 29/1 | ia. | | | | | | ALO | 28 | 1995 | 950 A |
| 4. SOCIAL SECURITY NUMBER | | S. SEX | 6. AGE | 'In yrs. les | t birthday) | | ER 1 YEAR | IF UNDE | | 7 DATE OF BUILTH | | 6. BIRTN | PLACE (State or Foreign |
| 135-30-9920 | - I | 1 🗌 M 2 💢 F | | 87 | YRS. | MONTHS | DAYS | HOURS | MIN. | Sept. 12, | 1907 | Country | "NY |
| 9a. FACILITY NAME (If not instit | | | | | | 9b. CIT | TY, TOWN C | R LOCAT | ON OF DE | | | UNTY OF D | EATH |
| Meridian Nu | ırsir | ng Home | | | | L | aPla | ta | | | Cha | arles | 3 |
| RESIDENCE OF DECE | | | | | | | | | | | | | |
| 100. STATE | Ob. COUNTY | 0cean | | | | | OR LOCAT | | | | | | 10d. INSIDE CITY LIMITS? |
| | | | | | | Ber | ke1 | y T | up. | | | | ŪŪŠYES 2 □ NO |
| 10e. STREET AND NUMBER | | | | | | | 101 | ZIP COD | _ | | 10g. CI | TIZEN OF W | HAT COUNTRY? |
| 68 Montse | errat | | | | | | | 08757 ป | | | | | Α. |
| 11. MARITAL STATUS 1 Never Married 2 Me 3 Widowed 4 Divorce | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES | 2 X N | MED IO | 13 | If yes, spo | cify Cubi | en, Mexica | NIC ORIGIN? (Specify Yen, Puerte Rican, etc.) | s or No- | 14. RACE Black Specif | - American Indian, White, atc. |
| 15. DECED (Specify only hi | ENT'S EDUC | | | 16a. DE | CEDENT'S | USUAL | OCCUPATIO | N | 201 | 16b. KIND OF BU | SINESS/IN | | |
| Elementary/Secondary (0-12 | - | College (1-4 or 5 a | -) | Ille. | Do NOT us | se retired. |) | | ng | | | | |
| 12 | | | | | Но | mem | aker | | | _ | Hon | ne | |
| 17. FATHER'S NAME (First, Midd | | | | | | | | 18. MOT | HER'S NA | ME (First, Middle, Maider | Surname) | | |
| Frank Perna | 1 | | | | | | | Vi | rgi | nia Ross | Per | na | |
| 194. INFORMANT'S NAME (Type | | | | 195 | . MAILING | ADDRES | SS (Street a | | | Palatin | | | |
| Joseph Mira | aglia | | | 1 | 485 | Tu | rkej | Tr | ail | Palatin | e,II | 1. 6 | 50067 |
| 20a. METHOD OF DISPOSITION 1 | | t ombine | | | | | Mem. | | rk | | nion- | City or Too | vn, State |
| 21. SIGNATURE OF FUNERAL S | SERVICE LICE | ENSEE | | | | 3 ² | WAYEAN | APPRE | SS OF FA | | | | 7110 |
| * David | C. l. | the | | 0094 | _ : | P | .0. | Box | 56 | O <mark>LS FUNE</mark> 7 LaP1at | a, MI | 206 | 46 |
| 23. PART i. Enter the dise shock, or hear | ases, or co | omplications that | caused se on e | the dea | ath. Do r | not ente | r the mo | in of dy | ing, sucl | h as cardiac or reap | iratory a | rreat, | Approximate interval Between |
| iMMEDIATE CAUSE (Final disease or condition resulting in death) | | RES | P/ | RA | TO DUENCE OF | R | / | FF | 711 | URE | | | Onset and Death |
| | | MET | A | 7 | DT | 10 | , | , | INI | P CA | 110 | 00 | |
| Sequentially list condition | s, b | DUE TO | | CONSEO | UENCE OF | 7 C | | - 0 | 1746 | n CH | YCL | - | |

sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION

28a. DATE OF INJURY (Month, Day, Year)

HOSPITAL:
1 Si Inpatient 2 ER/Outpatient 3 DOA

24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 | NO

28d. DESCRIBE NOW INJURY OCCURED

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

| 3 Suicide 4 Nomicide | 6 Could not be detarmined | 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) | 261. LOCATION (Street and Number or Rural Route Number, City or Yown, State) |
|----------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| a. CERTIFIER | CERTIFYING PNYSICIAN | Ir To the heat of my beautiful death and a state of the s | |

28b. TIME OF

29d. DATE SIGNED (Month, Day, Year)

8 · 2 8 · 95 29c. LICENSE NUMBER

26c. INJURY AT WORK?

1 YES 2 NO

OTHER: 4 M Nursing He

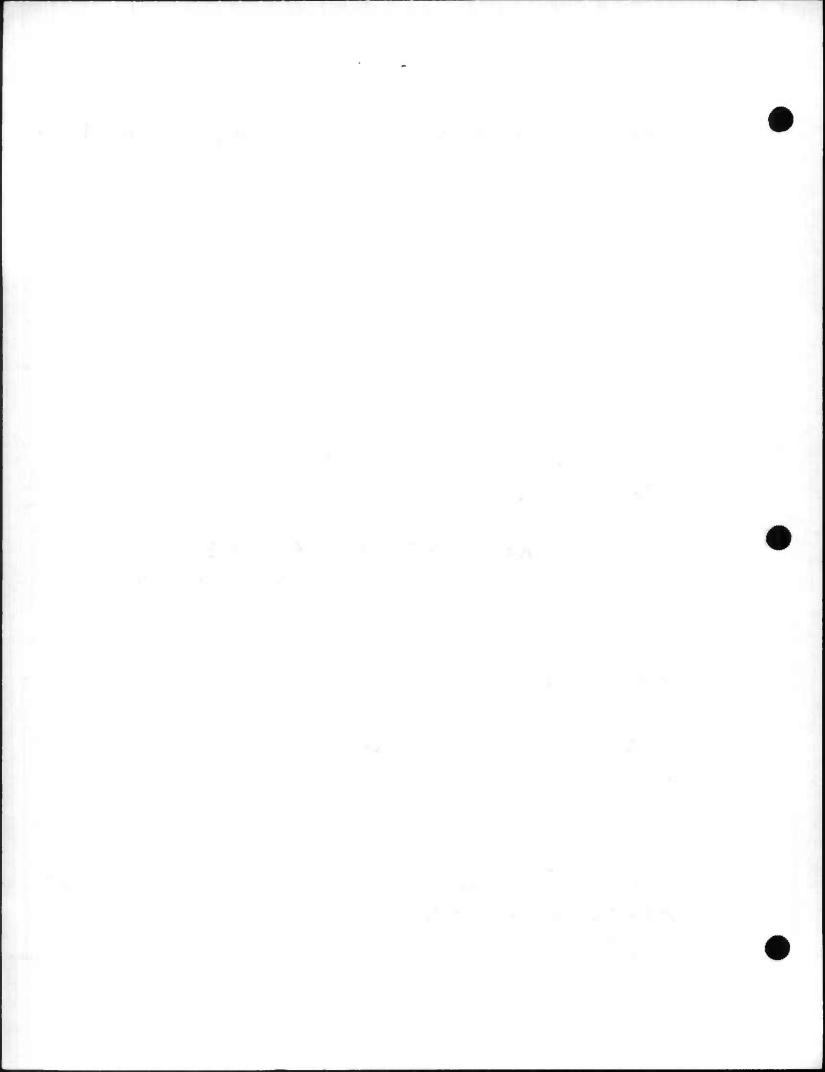
26. PLACE OF DEATH (Check only one)

6 - Residence 6 - Other (Specify)

CAUSE OF OEATN (ITEM 27) (Type, Print)

30. NAME AND ADDRESS OF PERSON

31. DATE FILED (Month, Day, Year)
AUG 2 9 1995 32. AUGISTRAD'S SIGNATURE



3. TIME OF DEATH 10:12 A

WashingTon

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 NO

Approximets

YEARS

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TYES 2 NO

29d, DATE SIGNED (Month, Day, Year)

AUGUST

intarvei Between

Onset and Death

REG. NO

Aug.

2

9c, COUNTY OF DEATH

USA

10g, CITIZEN OF WHAT COUNTRY?

Specify: White

2. DATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last

1 -

RECORDS, P.O. BOX 68760, DIVISION OF VITAL

IF UNDER 24 HRS. 7. DATE OF BIRTHOCT 1 M 2 X permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH Radfor DIRECTOR RESIDENCE O DECEDEN 10a. STATE 10h COUNTY 18c. CITY, TOWN OR LOCATION Prince Georges Clinton Maryland FUNERAL 104 STREET AND NUMBER 101, ZIP CODE 20735 page 5 should be detached for use as the burial-transit 7520 Surratts Road hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NG Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES COMPLETED BY 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) most of working dary (0-12) College (1-4 or 6+) Housewife Home notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fred Earl Reste Emma Leitha Grimes BE 19a. INFORMANT'S NAME (Type/Print) 19th. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4880 Quade Circle, Waldorf, MD 20602 2 Joan Paul 2 20a. METHOD OF DISPOSITION 26c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Burlei 2 Cremation 3 Removal from State n by the funeral director, removal. Trinity Memorial Gardens 8-29 Donation 5 Other (Specify) Waldorf, MD #1. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Osim Huntt Funeral Home, Inc. Benjamin Matthews M-00658 box 156, Waldorf, MD 20604-0156 medical 23. PART i. Enter the disesses, or complications that ceused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, filled in by t shock, or hasrt failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel and completely fille burial, cremation, the state disesse or condition RTERIOSCIENOTIC CARDIOVASCULAR resulting in death) death certificate be executed within traumatic event, OUE TO (OR AS A CONSEQUENCE OF). MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if sny, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to other **CAUSE** (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, o PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the FUNERAL DIRECTOR: After this certificate has been signed by the within 72 hours after death with the State Dept. of Health and Me MIANT: It Item 28 is marked, or item 23 shows any inju 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 1 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) OTHER: 1 YES 2 1 NO 1 Dipatient 2 ER/Outpatient 3 DOA g Home 5 🗆 Rasidence 6 🗀 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 29d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcide 281, LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. IMPORTANT: 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER THE OF See See See BE -185 2 ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PHILIP (87) 31. DATE FILED (Month, Day, Year)
AUG 2 9 32. REGISTRAR'S SIGNATURE
Julia Dhublear Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68769

| | 500 | | | | | | - L | 41130 |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------|
| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | ITMENT OF HE | ALTH AND I | MENTAL HYGIEN REG. NO | | |
| | 1. OECEDENT'S NAME (First, Middle, Last) | | 0411111 | IOAIL OI | PEAIN | 2. DATE OF DEATN | | 3. TIME OF DEATN |
| | ARTIE JOSEP | HINE MILI | ER | | | | 26, 19 | 95 945 A/W |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| | 216-05-2129 | 1 🗆 M 2 🔀 F | 75 YRS. | MONTHS DAYS | HOURS MIN. | APRIL 20 | 1920 | VIRGINIA |
| ~ | Sa. FACILITY NAME (If not institution, give | street end number) | | 96. CITY, TOWN OF | LOCATION OF DE | | | Y OF DEATN |
| DIRECTOR | 2510 ROOP ROAD | | | TANEYT | OWN | | CARI | ROLL |
| EC | 10a. STATE 10b. COUNT | ·Y | 10c. CIT | Y, TOWN OR LOCATIO | DN | | | 10d. INSIDE CITY |
| P | MARYLAND CAI | RROLL | T | ANEYTOWN | | | | LIMITS? |
| AL. | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| FUNERAL | 2510 ROOP ROAD | | | | 21787 | | | USA |
| 5 | 11. MARITAL STATUS | 12. WAS OECEDENT EVER IF FORCES? 1 YES | | 13. WAS OECE | NDENT OF HISPAN | IC ORIGIN? (Specify Yes | or No- 14 | Black, White, etc. |
| Β¥ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | | | NO Specify | | | Specify: |
| ED 6 | 15. OECEDENT'S EDU | ICATION | 10. DECEDENTIE | USUAL OCCUPATION | | Last amia acian | | CAUCASIAN |
| | (Specify only highest grade Elementary/Secondary (0-t2) | completed) College (1-4 or 5+) | (Give kind of v | vork done during most | of working | 16b. KINO OF BU | SINESS/INDUS | тнү |
| 릴 | 9th | Conlege (I-4 OI 5 F) | HOMEMAK | ER | | DOMES | TIC | |
| COMPLET | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NAM | RE (First, Middle, Meiden | Surname) | |
| BE (| ELLIS RAY | GLASS | | | FLORE | NCE | | THOMPSON |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Tow | n, State, Zip Co | ode) |
| | RICHARD L. MILLE | | | ROOP ROAL | | YTOWN, MAR | YLAND | 21787 |
| | 20a. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Rem | noval from State Cem | netery, crematory or of | | | DATE 20c. LO | CATION — CIT | y or Town, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIN | S | MITHSBUR | G CREMATO | RY | 18/28 SMT | THSBUE | G. MARYLAND |
| | · DI | . () | | 22. NAME AND | ADDRESS OF FAC | 136 EAS | T BALI | IMORE STREET |
| Н | 1. Nei | ren frede | 2 | SKILE | S FUNERA | AL HOME T | ANEYTO | WN, MD 21787 |
| | 23. PART I. Enter the diseases, or ahock, or heart fellure. | complications that caused List only one cause on ea | the deeth. Do n ach line. | ot enter the mode | of dying, auch | an cardiac or reap | ratory arrea | t, Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | 11110 | | | | | | Onset and Death |
| | resulting in death) | a. HSCV | CONSEQUENCE OF | n. | | | | |
| _ | _ | | COMSEQUENCE OF | | | | | |
| 0 | | Hi Rente | 19110 | | amos | 111 | | |
| | Sequentially list conditions, | · Hyperte | CONSEQUENCE OF | | aner | w | | |
| CATI | if any, leading to immediate cause. Enter UNDERLYING | · Hyperte | CONSEQUENCE OF | | aner | m | | |
| TIFICATI | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. Hyperfe OUE) TO (OR AS A C. Shi Cl | CONSEQUENCE OF | 7: | aner | w | | |
| ERTIFICATI | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | b. Hyperfe OUE) TO (OR AS A C. Shi Cl | eetes | 7: | aner | w | | |
| AL CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | b. Hyperto (OR AS A c. DUE TO (OR AS A d. | CONSEQUENCE OF |); ;); | | | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. Hyperto (OR AS A c. DUE TO (OR AS A d. | CONSEQUENCE OF |); ;); | | Part I. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | b. Hyperto (OR AS A c. DUE TO (OR AS A d. | CONSEQUENCE OF |); ;); | | Part I. 24a. WAS AN | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | b. Hyperto (OR AS A c. DUE TO (OR AS A d | CONSEQUENCE OF | n the underlying | | Part I. 24a. WAS AN PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | b. Hyperto (OR AS A C. DUE TO (OR AS A d | CONSEQUENCE OF | n the underlying o | cause given in f | Part I. 24a. WAS AN PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | b. HUE TO (OR AS A c. DUE TO (OR AS A d | CONSEQUENCE OF ut not resulting I F DEATH YE 26. PLACE OF GEAT | n the underlying o | cause given in f | Part I. 24a. WAS AN PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | DUE TO (OR AS A d. RIBUTE TO CAUSE O | CONSEQUENCE OF ut not resulting I F DEATH YE 26. PLACE OF GEAT | S NO NO OTHER: | UNCERTAIN 5 X Residence (1) AT | Part I. 24a. WAS AN PERFOR | MED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | b. DUE TO (OR AS A c. DUE TO (OR AS A d | CONSEQUENCE OF ut not resulting I F DEATH YE 26. PLACE OF GEAT stient 3 DOA 28b. TIMI | S NO | UNCERTAIN 5 X Residence (1) AT | Part I. 24a, WAS AN PERFOR 1 YES 2 | MED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1. Netural 5 Pending | b. DUE TO (OR AS A c. DUE TO (OR AS A d | CONSEQUENCE OF ut not resulting I F DEATH YE 28. PLACE OF OEAT stient 3 □ DOA 28b. TIME INJI — At home, ferm, e | S NO | UNCERTAIN 5 X Residence 6 77 AT | Part I. 24a, WAS AN PERFOR 1 YES 2 | MED? NO NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined | DUE TO (OR AS A d. RIBUTE TO CAUSE O HOSPITAL: 1 Inpetient 2 ER/Outp 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec | CONSEQUENCE OF ut not resulting I F DEATH YE 28. PLACE OF OEAT stient 3 □ DOA 28b. TIME INJI At home, ferm, s | n the underlying of the underlying of the underlying of the underlying of the underlying Norme to the underlying the underlying the underlying to the underlying the underlying the underlying to the underlying of the underl | UNCERTAIN 5 X Residence (17 AT 77 NO | Part I. 24a. WAS AN PERFOR 1 VES 2 Other (Specify) 28d. DESCRIBE HOW II City or Town, Stete) | NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only) 1 CERTIFYINO PNYS | DUE TO (OR AS A C. DUE TO (OR AS A d. RIBUTE TO CAUSE O HOSPITAL: 1 Inpetient 2 ER/Outp 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec | CONSEQUENCE OF ut not resulting I F DEATH YE 28. PLACE OF OEAT stient 3 DOA 28b. TIME INJI At home, ferm, a | n the underlying of the underlying Nome to the underlying of the under | UNCERTAIN 5 X Residence (17 AT (17) 5 2 \(\) NO | Part I. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) 26d. DESCRIBE HOW III City or Town, Stete) | NO N | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO Record Route Number, |
| PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | DUE TO (OR AS A c. DUE TO (OR AS A d | CONSEQUENCE OF ut not resulting I F DEATH YE 28. PLACE OF OEAT stient 3 DOA 28b. TIME INJI At home, ferm, a | n the underlying of the underlying Nome to the underlying of the under | UNCERTAIN 5 X Residence (17 AT (17) 5 2 \(\) NO | Part I. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) 26d. DESCRIBE HOW III City or Town, Stete) | NO N | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO Record Route Number, |
| BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only) 1 CERTIFYINO PNYS | DUE TO (OR AS A c. DUE TO (OR AS A d | CONSEQUENCE OF ut not resulting I F DEATH YE 28. PLACE OF OEAT stient 3 DOA 28b. TIME INJI At home, ferm, a | The underlying of the underlyi | UNCERTAIN 5 X Residence (17 AT (17) 5 2 \(\) NO | Part I. 24a. WAS AN PERFOR 1 YES 2 Other (Specify) 28d. DESCRIBE HOW II 28d. LOCATION (Street a City or Town, Stele) to the cause(a) end man time, data end placa, an | NO NO NJURY OCCUP and Number or | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO Record Route Number, |

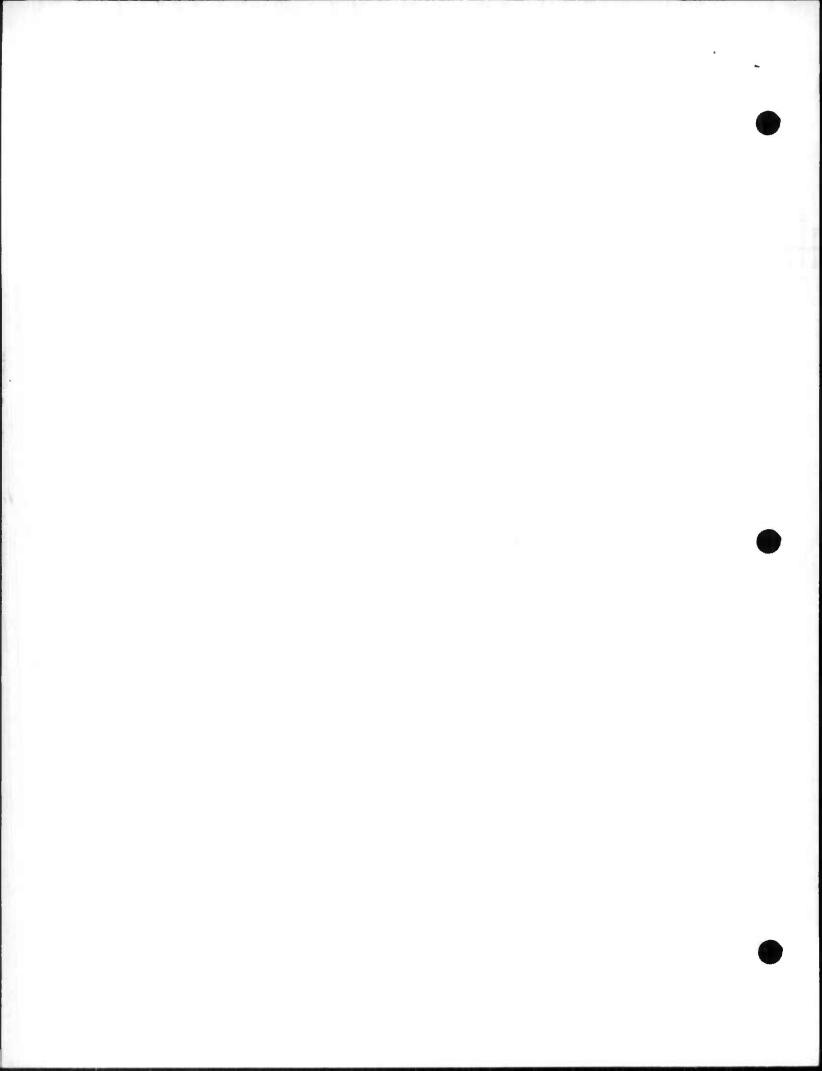
8914 AUGUST 28 1995 49 FREDERICK STREET M.D. IGLESIA, TANEYTOWN, MARYLAND 21787

31. DATE FILED (Month, Day, Year)

AUG 2 8 1995

WENIFREDO N.

32. REGISTRAR'S SIGNATURE



2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

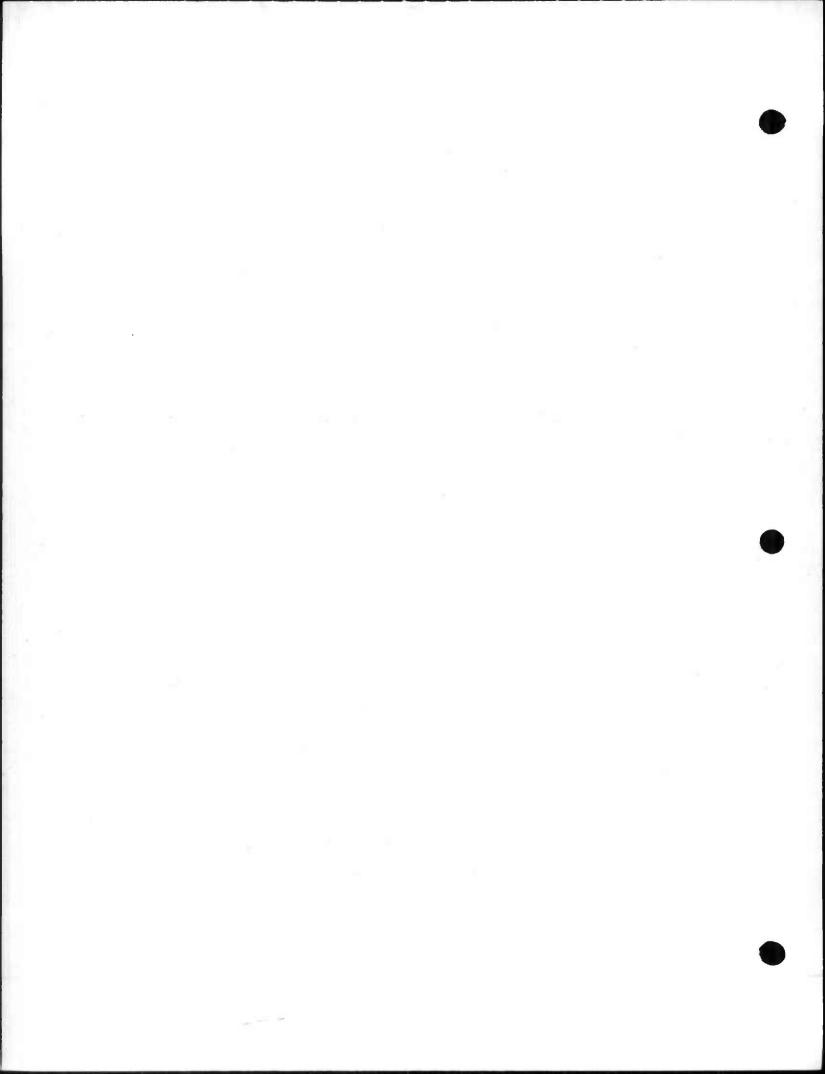
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1995 YEAR August 20, Jane Rebecca MAY 2:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign (Month, Dey, Year)
FEB. 10,1937 HOURS 215-34-2944 1 M 2 X F 58 YRS MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4103 Araby Church Road Frederick Frederick RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND FREDERICK FREDERICK 1 WES 2 NO Dermit, FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 4103 ARABY CHURCH ROAD 21704 funeral director, page 5 should be detached for use as the burial-transit UNITED STATES retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 □ YES 2 ▼ NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY Specify: WHITE 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION sectly only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe MONTGOMERY COUNTY SCHOOLS Elementary/Secondary (0-12) College (1-4 or 5+) 12 BUS DRIVER 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Meiden Surname) CRITTENDEN WALKER LENA E. LENHART BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 FRANCIS Α. 4103 ARABY CHURCH ROAD FREDERICK, MD. 21704 death. Page 6 may be 99 29a METHOD OF DISPOSITION

1 Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must MT. OLIVET CEMETERY 4 Donation 8 Other (Specify) 8/22/95 FREDERICK, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038 LAYTONSVILLE, MARYLAND been signed by the attending physician and completely filled in by the 1st Health and Mental Hygiene prior to burial, cremation, or removal, shows any Inline. medicai 23. PART I. Enfer the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line Interval Retween IMMEDIATE CAUSE (Fine) Onset and Death the disease or condition ADENOCARCINOMA OF THE LUNG 1 MONTH event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERICARATTS shows any 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗹 NO 🗆 UNCERTAIN 🗆 PHYSICIAN: certificate has be the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO OR ATTENDING PHYSICIAN: 4 Nursing Home SA Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28c. INJURY AT 28e. DATE OF INJURY (Month, Day, Year) 26d. DESCRIBE HOW INJURY OCCURED this c 28b. TIME OF INJURY marked, 1 Natural
2 Accident BY 1 YES 2 NO After Investigation 3 🗍 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) .69 COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 determined hours Hem 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(e) end manner ee stated. FUNERAL within 72 1 STANT: If TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II realigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month. Day, Year) D 31761 August 20,1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) O'Connor MD 501 West Seventh Street, Frederick, Maryland 21701 Dr. Brian M. 36. REGISTRAR'S SIGNATUSE
FULLA DRUGGER RENDELL 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020

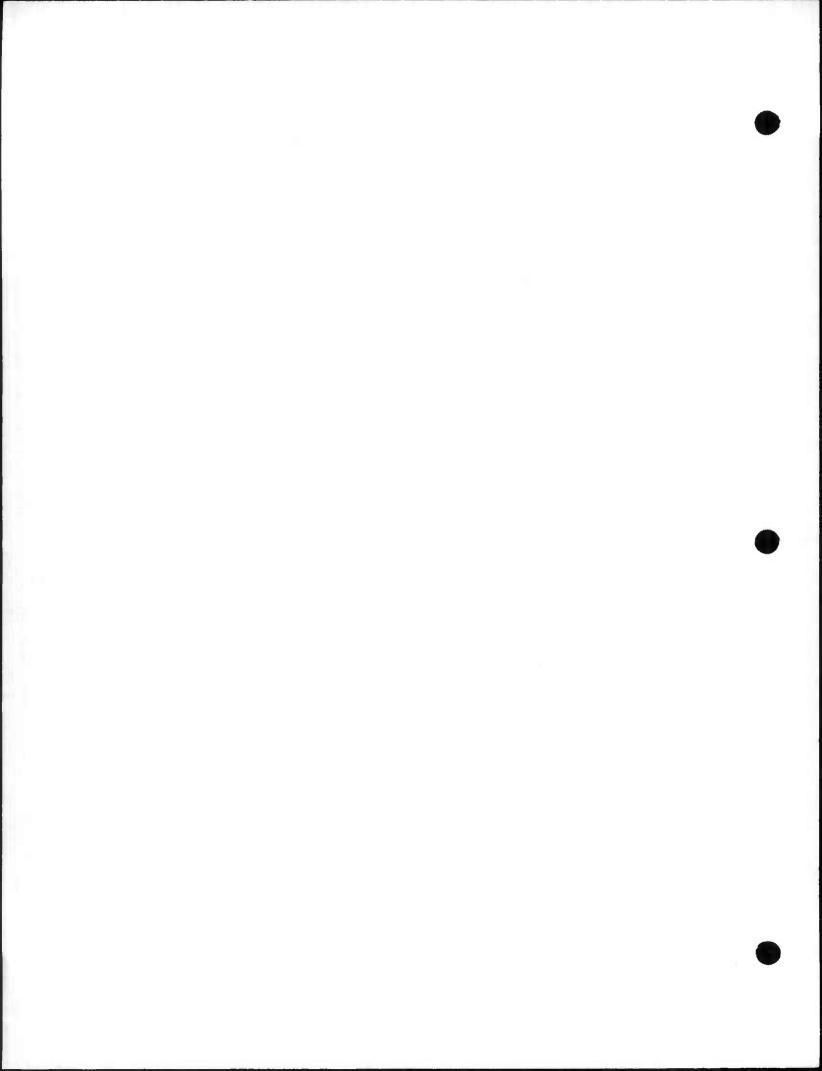
1

| BALTIMORE, MARYLAND 21215-0020 | z-t hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | he medical examiner must be notified at once. |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| FOR STATE REGISTRAR | STATE OF | MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|------------------------------|----------|----------------------------------------------------------|----------------------------|
| CLIFFORd. | Ray | meiton | 2. DATE OF GEATH DAY |
| COULT OF CHAPTER AND ADDRESS | | | |

| $\overline{}$ | | | | | | IVAL | | | | HEG | . NO. | | |
|---------------|----------------------------------------------------|---------------------------|----------------------------------------|-----------------|-----------------|--------------|-----------|-------------|------------|--------------------------------------------|-------------------------|-----------------|--------------------------------------------|
| | 1. DECEDENT'S NAME (First, | Middle, Last) | Dow | ho - | ilaa | | | | | 2. DATE OF OEA | PAM | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMB | ER ER | Ray 5. SEX | 6. AGE (in yrs. | SITUN | IE IMPER | L VEAD | T or unines | | Aug | | | 7:33A M |
| | 505-54-7058 | | 1 👿 M 2 🗆 F | 50 | YRS. | MONTHS | DAYS | HOURS | MIN. | 7. DATE OF BIRD (Month, Day, Ye | unr) | Count | |
| | 9a. FACILITY NAME (If not ins | stitution, give s | 21 | 30 | | ah CITY | TOWN (| OR LOCATI | 011.05.0 | Sep 7, | | | raska |
| œ | Suburban Hos | | Total and Harrisa | | | | | | ON OF D | EAIH | | COUNTY OF I | |
| DIRECTOR | RESIDENCE OF DEC | EDENT | | | | Be | thes | da | | | N | ontgo | mery |
| | 10a. STATE | 10b. COUNTY | | | 10c, CIT | Y, TOWN (| OR LOCA | TION | | | | | 10d. INSIDE CITY |
| | Maryland | Mont | gomery | | Kei | nsing | gton | | | | | | 1 YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | | 10 | . ZIP COD | E | | 10g. | CITIZEN OF | WHAT COUNTRY? |
| | 11113 Stillw | ater l | Avenue | | | | | 2089. | 5 | | τ | SA | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 K | Mandad | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. | ARMED | 13. | WAS OEC | CENOENT C | OF HISPA | NIC ORIGIN? (Speci on, Puerto Rican, et | fy Yes or No | - 14. RAC | E — American Indian, k, White, etc. |
| à l | 3 Widowed 4 Divor | | FORCES? 1 IF YES, GIVE W 1961- | AR OR DATES | | | | 2 X NO | | | ·) | Spec | |
| | | OENT'S EDUC | | | DECEDENT'S | | | | 20 | 16b. KIND O | F BUSINESS | /INDUSTRY | |
| COMPLETED | Elementary/Secondary (0- | | College (1-4 or 5 a | | life. Do NOT us | se retired.) | during me | of WORM | ·v | | | | |
| È | | | 5+ | A | ttorn | ey | | | | Law | | | |
| | 17. FATHER'S NAME (First, Mic | ddle, Last) | | | | | | 16. MOTI | HER'S NA | ME (First, Middle, M | eiden Suman | oe) | |
| NE NE | Emmet Avent | | | | | | | | | Melton | | | |
| 2 | 19s. INFORMANT'S NAME (Ty | | | | | | | | | Route Number, City of | | | |
| | Susan Pollar | | ton | | | | | | Ave. | , Kensin | | | |
| | 1 Suriel 2 Cremetion 4 Donation 5 Other | n 3 🗆 Remo | oval from State | compton | Crematory or o | ther place! | | | 0.0 | | | - City or To | |
| 1 | 21. SIGNATURE OF TUNERAL | | ENSEM. | I Quan | tico I | Vatio | nal | Cem. | .,08 | -21-95 | Trian | gle, | Virginia |
| - 1 | - X/6.1 | . 0 | 1.11 | 5. | | | | | | Funeral | Home | | |
| 4 | Mely | 01 | Mercac | | | 11 | L800 | New | Ham | pshire A | ve,Si | lver : | Spring, MD. |
| | 23. PART I. Enter the dis ahock, or he | seasea, or c | omplications that List only one cau | caused that | daath. Do r | not antar | tha mo | da of dyl | ing, suc | h aa cardiac or | reapiratory | arreat, | Approximate |
| | IMMEDIATE CAUSE (Fine | | | | | | - / | | | | | | Interval Batween Onset and Death |
| | disease or condition resulting in death) | → , | F | CES PI | rato | 19 | 10 | ailu | re | | | | Imiv. |
| 1 | | | | | | , | | | | | | | |
| 5 | Sequantially flat condition | ona, | DUE TO | OR AS A CONS | cal | LCE | mi | a | | | | | 4 weeks |
| Ţ | if any, leading to immed cause. Enter UNDERLY!! | | | -VN9 | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injur that initiated events | у 🕻 " | DUE TO | OR AS A CONS | EOUENCE OF | P): | - | | | | | | |
| | resulting in death) LAST | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| N. CAL | PART II. Other aignificar | condition | a contributing to | death but not | t reaulting i | in tha un | derlying | g cause g | lven in | | S AN AUTOP | SY 24b | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO |
| ś I | - | | | | | | | | | 1 🗆 YI | S 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| Ĕ | | | | | | | | | | | | | 1 YES 2 NO |
| Ė | DID TOBACCO US | | RIBUTE TO CA | | | | | UNC | ERTAI | N 🗆 | _ | | |
| 2 | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | ACE OF DEAT | OTHER | | | | | | | |
| FITSICIAN | 1 YES 2 NO | | 1 Inpatient 2 | | _ | 4 🗆 Nun | lng Hom | | sidence | 6 Other (Specify | | | |
| - 10 | M | ending | 28s. DATE OF (Month, Da | ny, Year) | 28b. TIM | URY M | | PK7 | 1 | 28d. DEŞCRIBE H | OW INJURY | OCCURED | |
| | 2 Accident | rvestigation | 28a PLACE O | F INJURY — At I | home term of | | | ES 2 | NO | | | | |
| 3 | | could not be etermined | building, | atc. (Specify) | nome, term, t | Areet, IECT | ory, omic | | | 28f. LOCATION (S City or Town, | treet and Nur State) | nber or Rurel i | loute Number, |
| MPLE | 29a. CERTIFIER 1 CERTI | FYINO PHYSIC | CIAN: To the best of | my knowledge. | death occurry | or at the ti | me dete | and place | and due | to the council or | Landin E | adata d | |
| | | | | | | | | | | | | |) and menner es stated. |
|) | 29b. SIGNATURE AND TITLE | | | - 1 | | | | 29c. LICE | | | | | |
| 4 | Dann | 1H | 1 2 | -11- | mDI | PhD | | Zac. LICE | | 1190 | | | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUS | E OF DEATH (IT | 4 | | | 0 | 9 | 1110 | | aug. 1 | .8, 1995 |
| | J. Garrett | Reillv | | | | | nad | . Roo | kvi | lle. Mar | vland | 20852 | |
| | 31. DATE FILER (MOORT), Day, N | bar) | 3º REGISTRAL | | | 11 | Juu | , 100 | , at v II. | Lic, Hal | Tanu | 20032 | |
| | AUG 21 | 1995 | States alle | roll-scalar | dall | | | | | | | | |





3. TIME OF DEATH

10d. INSIDE CITY

20878

Approximate Interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE

1 YES 2 NO

OF DEATH?

t X YES 2 NO

10:29 P

2. DATE OF DEATH

t. DECEDENT'S NAME (First, Middle, Last)

ARTIN 31. DATE FILED (Month, Day, Year) AUG 22

1995

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | 2 |
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| | COURT DO ATTENDIAN CHARGE THE TAX AND |

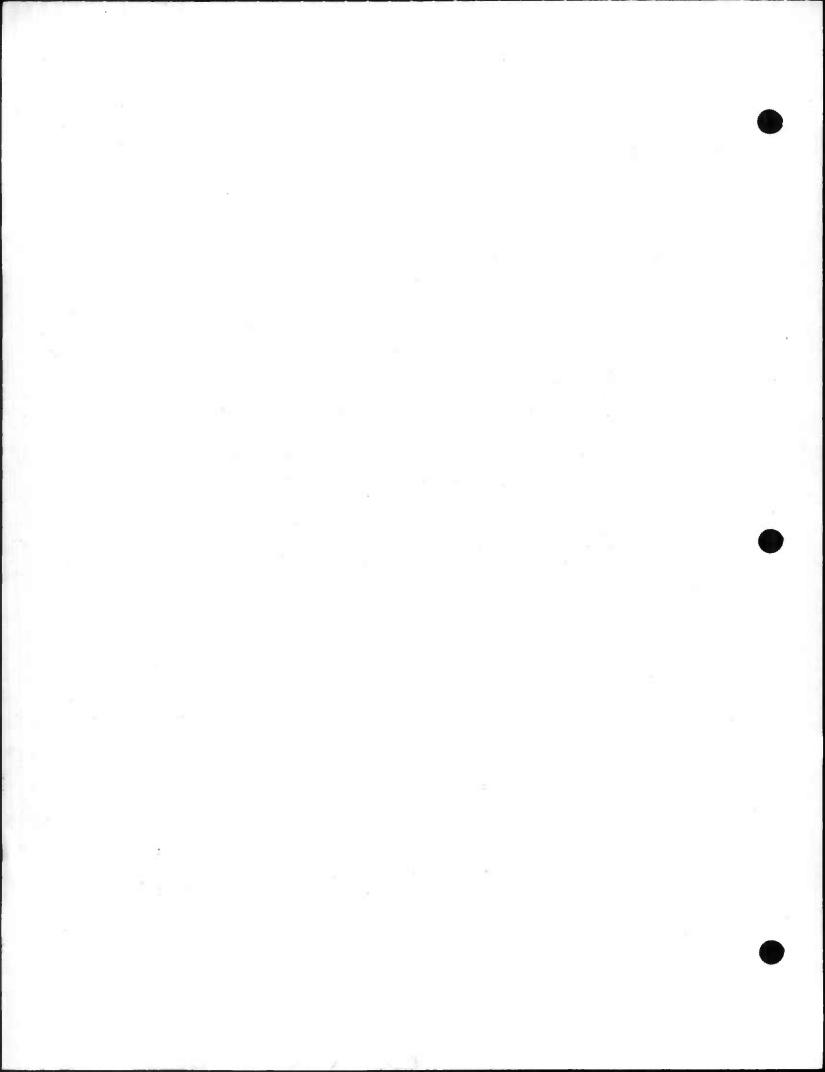
SARAH LOU MILLS August 10 1995 TEAR 4. SOCIAL SECURITY NUMBER 230-54-2592 6. AGE (In vrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) March 14, 1912 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 83 1 M 2 XF DAYS HOURS VDS Greer, S.C. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Darnestown 10e. STATE 10h COUNTY Maryland Mantagrery permit. FUNERAL 10e. STREET AND NUMBER tor. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13901 Turkey Run Court 20878 U.S.A. funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY White 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home tr. FATHER'S NAME (First Middle, Last)
Frank William Green 16 MOTHER'S NAME (First, Middle, Maiden Surname) to BE notified 190. INFORMANT'S NAME (Type/Print)
Raymond R. Mills, Jr. 1995 MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13901 Turkey Run Court, Darnestown, MD 2 be 20e. METHOD OF DISPOSITION
t Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Cemetery, cremetory or other place) Geo. Vash. 8/ 8/11/95 Washington, DC 4 X Donation 5 Other (Specify) H. SIGNATURE OF UNERAL SERVICE LICENSFF examiner Columbia Mortuary Services, Inc. 225 Missouri Ave., NW, Washington, DC 20011 completely filled in by the fall, cremation, or removal. medical 23. PART I. Enter the diseases, or complete ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List ne cause on each line. 9 IMMEDIATE CAUSE (Final the disease or condition_ NEUMONIA resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): burial, ISEASE) Arkinsons CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST the atten Mental PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 3 2 DISTOCATED JAWS signed 1 TES 2 NO DONATREMIA t. of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by 23 25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATH (Check only one) the State HOSPITAL OTHER: t TYES NO Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 8 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? this marked, 1 Natural М 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) ETED 6 Could not be DIRECTOR: hours after 4 Homlelde datermined 28 item COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER; On the besis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) end manner ee stated. 286 SIGNATURE AND TITLE OF CERT 29c. LICENSE NUMBER 29d. DA E SIGNED (Month, Day, Year) BE 07162 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print

Julia Davidson Rardall

Shady Grove

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-727 9/16/95 t.t

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| A DECEMENT NAME OF A ASSAULT | | CERTIFIC | CATE OF | DEATH | | REG. NO. | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) |) | | | | MONTH | OF DEATH | YEA | 3. TIME OF DEATH |
| CROSBY KOCH | MORRIS | JR. | | | AUG | UST 1 | 5,199 | 5 9:22 A |
| 4. SOCIAL SECURITY NUMBER 309-78-5595 | 1 ▼M 2 □ F | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | (Month | OF BIRTH 1, Day, Year) 28,19 | Co | RTHPLACE (State or Foreign unity) INDIANA |
| 9a. FACILITY NAME (If not institution, give PRINCE GEORGES RESIDENCE OF DECEDENT | | | 9b. CITY, TOWN C | R LOCATION OF DI | EATH | | PRIN | F DEATH CE GEORGES |
| 16a. STATE 10b. COUNT | NCE GEORGES | | TOWN OR LOCAT | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10s. STREET AND NUMBER | ELAINE DR. # | | | ZIP CODE 20784 | | | | OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 M Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | R IN U.S. ARMED | | ENDENT OF HISPAI | in, Puerto I | | or No — 14, R | ACE — American Indian, lieck, Whita, atc. |
| 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use | ork done during mo | DN st of working | 16b. | KIND OF BUSI | NESS/INDUSTR | Y |
| 17. FATHER'S NAME (First, Middle, Lest) CROSBY KO | OCH MORRIS | SR. | | 18. MOTHER'S NA | ME (First, I | | umame) JSTIN | |
| 190. INFORMANT'S NAME (Type/Print) CHERYL | MORRIS | | | nd Number or Rural | Route Numi | | |) |
| 20s. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rai 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF CHAMBERS | F DISPOSITION (No | me of | 8/2 | | ATION — City o | Town, Stata |
| 23. PART I. Enter the diseases, or shock, or heart fellure iMMEDIATE CAUSE (Final disease or condition resulting in dasth) | e. List only one cause or | | of enter the mo | de of dying, suc | h as cere | disc or respin | - (| MD. 20737 Approximate Interval Betwee Onset and Date |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | bDUE TO (OR A | IS A CONSEQUENCE OF |): | | | | | |
| PART II. Other significant condition | ona contributing to deat | h but not reculting in | the underlyin | g cause given in | Part I. | 24a. WAS AN A | | |
| | | | | | | VYES 2 | | 246. WERE AUTOPSY FINDIN- AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH | H (Check only one) |] UNCERTAI | N 🗆 | VSC YES 2 | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 NO | HOSPITAL: | 26. PLACE OF DEATH | OTHER: 4 Nursing Hon | e 5 🗆 Rasidenca | 6 Othe | er (Specify) | □ NO | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 NO 27. MANNER OF DEATH 1 Netural STEPPING | HOSPITAL: 1 Inpetient X XER/C 28a. DATE OF INJUI (Month, Day, Yes | 26. PLACE OF DEATH Outpatient 3 DOA | OTHER: 4 Nursing Hon OF 28c. IN. | | 6 Othe | er (Specify) | UURY OCCURE | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 NO 27. MANNER OF DEATH 1 Netural Bending | HOSPITAL: 1 Inpettent X XERVC 28a: DATE OF INJUI (Month, Day, Yee 8-15-95 28a: PLACE OF INJUI | 26. PLACE OF DEATH Dulpstient 3 DOA RY 26b. TIME INJU 4:00 URY — At home, farm, st | OTHER: 4 Nursing Hon OF 28c. IN. JRY M 1 Itreet, factory, office | He 5 Assidence FURY AT PIRK? YES 2 XXIO | 6 Other | OF (Specify) SCRIBE HOW IN | UJURY OCCURE S) WITH nd Number or Ru 8400 8L | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO P SUBJECT SWALL DRUGS THE ROUTE Number, K. BALTIMORE A |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 NO 27. MANNER OF DEATH 1 Netural 1 Netural 2 Naccident 3 Suicide 8 Could not b 4 Homicide 8 Could not b 4 Check only 1 CERTIFYING PHY | HOSPITAL: 1 Inpettent X XER/C 28e. DATE OF INJU (Month, Dey, Yee 8-15-95 28e. PLACE OF INJU | 26. PLACE OF DEATH Dutpetient 3 DOA RY 10 26b. TIME INJU 4:00 URY — At home, farm, st Specify) STRE nowledge, death occurrent | OTHER: 4 Nursing Hon SOF AM 1 Itreet, factory, offic ET d st the time, date | Ne 5 Rasidenca URY AT PRIC? YES 2 ANO a | e Other | or (Specify) SCRIBE HOW IN TIC BAG(CATION (Street as or Town, State) EGE PARK use(e) and manif | UURY OCCURES NITH MARYLA NARYLA Der se stated. | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D SUBJECT SWALL DRUGS JUST ROUTE Number, K. BALTIMORE AND |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 NO 27. MANNER OF DEATH 1 Netural 1 Netural 2 Naccident 3 Suicide 8 Could not b 4 Homicide 8 Could not b 4 Check only 1 CERTIFYING PHY | HOSPITAL: 1 Inpetient XXER/C 28a. DATE OF INJUI (Month, Day, Yee 8-15-95 28a. PLACE OF INJUI building, etc. (3) YSICIAN: To the best of my kn NER: On the basis of axamin | 26. PLACE OF DEATH Dutpstient 3 DOA RY 26b. TIME INJUL 4:00 URY — At home, ferm, st Specify) STRE nowledge, death occurre- stion and/or investigation | OTHER: 4 Nursing Hon OTHER: 5 OF 28c. IN. HY A M 1 Rreet, factory, office E T d at the time, data n, in my opinion, of | Ne 5 Rasidenca URY AT PRIC? YES 2 ANO a | 6 Other 28d. DE: PLAS 28f. LOC Cny COLL: to the ca | or (Specify) SCRIBE HOW IN TIC BAG(CATION (Street as or Town, State) EGE PARK use(e) and manif | JURY OCCURE S) WITH MARYLA MARYLA d dua to the ceu | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D SUBJECT SWALL DRUGS JUST ROUTE Number, K. BALTIMORE AND |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detable within 72 hours after death with the State Debt, of Health and Mental Hotiere order to burial, cemation, or named. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other baumatic event, the medical examiner must be notified at on |
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MRT taomer FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF/HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARTA 1995 EAR MAVRIKAKIS August 17, 11:40 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1912 IF UNDER 1 YEAR 1 M 2 F 226-84-4928 83 YRS. June 12,1995 Greece 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 7611 Coddle Harbor Way DIRECTOR Potomac Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Montgomery Maryland Potomac 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7611 Coddle Harbor Lane 20854 Greece 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or 14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 IF YES, GIVE WAR OR OATES 1 Never Married 2 Married BY Specify 3 🔯 Widowed 4 🗌 Divorced White ETED 15. OECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade completed) stary/Secondary (0-12) College (1-4 or 5 +) COMPL 8 0 Homemaker At Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname Dimitri S. Mavrikakis Eleni Unobtainable BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Juliani Gatzoulis 7611 Coddle Harbor WayPotomac, Maryland20854 20a, METHOD OF DISPOSITION
1 A Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 8-19-95 Silver Spring, Maryland 21. SIGNATURE OF FUNEJRAL SERVICE-EXCENSES 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, Maryland 20904 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition Wine Cancer resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Unstable CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 1-NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) 1 TES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA ng Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO В Investigation 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 | Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner as stated. 29b. SIGNATURE AND TILE OF CERTIFIER 29c. LICENSE NUMBER BE (I'M E96348 11020104 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

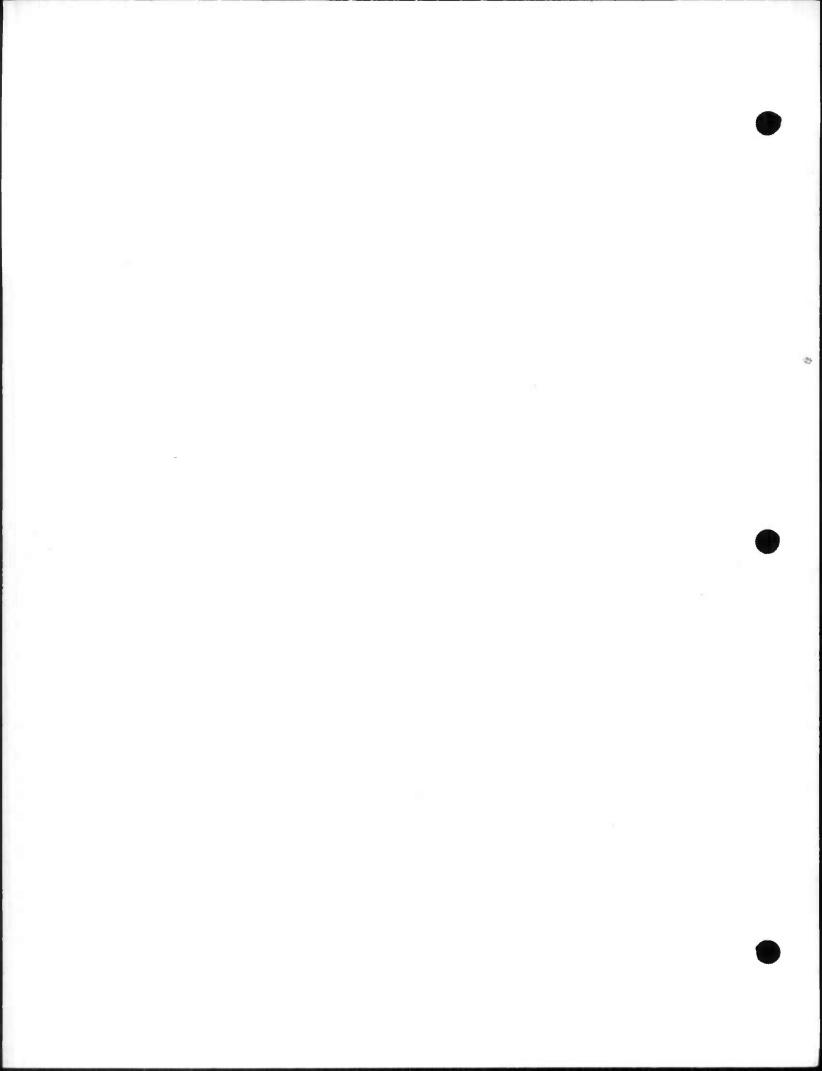
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending bracitian | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be nied within 72 hours arer deam with the State Dept. of Hearth and Merita Mygeine prior to buhat, cremation, or famonal. IMPORTANT: If item 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | ELEANOR | E. MYER | | | August 20 | 1995 | 12:30 PM m | | | | |
| | 4. SOCIAL SECURITY NUMBER | | | NDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTI | HPLACE (State or Foreign | | | | |
| | 579-60-0395 | 1 DM 2 NF 95 YRS. MONTHS DAYS HOURS MNN. (Month, Day, Year) Country) April 8, 1900 Wash., | | | | | | | | | |
| œ | 9a. FACILITY NAME (If not institution, give Manor Care | street and number) | 9b. | CITY, TOWN OR LOCATION OF | DEATH 9c. COUNTY OF DEATH | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | Silver Spri | ng | Montgomery | | | | | |
| REC | 10a. STATE 10b. COUNT | гү | 10c. CITY, TO | WN OR LOCATION | | 10d. INSIDE CITY | | | | | |
| | | tgomery | Si | lver Spring | | | LIMITS? 1 XXYES 2 □ NO | | | | |
| 3AL | 100. STREET AND NUMBER | 1 | | 10f. ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | |
| FUNERAL | 10317 Royal Road | | | 20903 | | | States | | | | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 13. WAS DECENDENT OF HISP If yes, specify Cuban, Maxi | can, Puerto Rican, etc.) | or No- 14. RAC Blac | E — American Indian, ik, White, etc. | | | | | |
| ВУ | 3√X Widowed 4 ☐ Divorced | IF YES, GIVE WAR OR DA | 1 TES 2 NO Spec | city: | Specify: White | | | | | | |
| COMPLETED | | | | | | | | | | | |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | iife. Do NOT use retii | ed.) | Admi | nistrati | .on/ | | | | |
| MP | 12 | | Secretary | - Government | - 1 | Thite Hou | se | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Julius Eisenber | ico | | | NAME (First, Middle, Meiden | 1 | | | | | |
| 88 | 19a. INFORMANT'S NAME (Type/Print) | 188 | Tab MAN INC ADD | Mary E | llen Hepbur | | | | | | |
| 2 | Barbara Myer Si | tevens | | Royal Road, S | | | 0003 | | | | |
| | 20s. METHOD OF DISPOSITION | 20b. | PLACE AND DATE OF DIS | POSITION (Name of | DATE 20c LO | CATION — City or To | | | | | |
| | 1 Burial 2 Cremation 3 Ran 4 Donalion 5 Other (Specify) | noval from State ceme | etery, cremetory or other particular in the color of the | Crematory 8/21 | /95 Bre | ntwood, | MD | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | | 1 -1 | 22. NAME AND ADDRESS OF | FACILITY | | ALD. | | | | |
| | Mani VI | ient The | lance | Hines-Rinald 11800 New Ha | i Funeral H | lome | 0 1 15 | | | | |
| | 23. PART I. Enter the diseeses, or | complications that caused | the deeth. Do not e | nter the mode of dying, au | ich aa cerdlec or raapi | ratory arrest, | Approximate | | | | |
| | IMMEDIATE CAUSE (Finel | . List only one cause on ea | ch line. | | | | Interval Between Onset and Death | | | | |
| | disease or condition resulting in death) | rnei | imonia | | | | Days | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| ON | Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ¥ | cause. Enter UNDERLYING | | | | | | | | | | |
| Ĕ | CAUSE (Disease or Injury that initiated events | OUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | |
| AL C | PART II. Other significant condition | na contributing to death be | ut not resulting in the | underlying ceuse given i | n Part I. 24s. WAS AN | ALITOPSY 24h | , WERE AUTOPSY FINDINGS | | | | |
| CA | TECTOS COMPANY (1500) | | | | | | | | | | |
| MEDIC | Charles Heart Folly | | | | | | | | | | |
| | DID TOBACCO USE CONT | | | □ NO □ UNCERTA | IN ISO | | 1 YES 2 NO | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 6. PLACE OF DEATH (C | | | | | | | | |
| Sic | 1 TES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Oulpa | | HER: Nursing Home 5 - Residence | 8 Other (Specify) | | | | | | |
| PH | 27. MANNER OF DEATH 1 Netural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. OEŞCRIBE HOW II | NJURY OCCURED | | | | | |
| В | 1 Natural 5 Pending 2 Accident Investigation | | | 1 YES 2 NO | | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, atc. (Speci | — At home, farm, street, | lactory, office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| COMPLETED | 4 nomicios determined | | | | | | | | | | |
| MP | 29a. CERTIFIER (Check only) (Ch | | | | | | | | | | |
| | one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the lime, date end place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNEO (Month, Day, Your) August 70, 199 | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | / / / | | עדען. | 2 80 | Mugu | T 20,175 | | | | |
| | | | | elBowie Rd | #307 1 | surel H | 10 25708 AM | | | | |
| | 31. DATE FILED (Month, Day, Year) | 22. REGISTRAR'S SIGNA | TUME | -90-18/14 | | 44/6/11 | | | | | |
| | AUG 22 1995 | Alia Davidson R | ardall | | | | | | | | |



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DIVISION OF VITAL RECORDS, P.O. BOX 687

| TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and competity filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiere prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be noted. |
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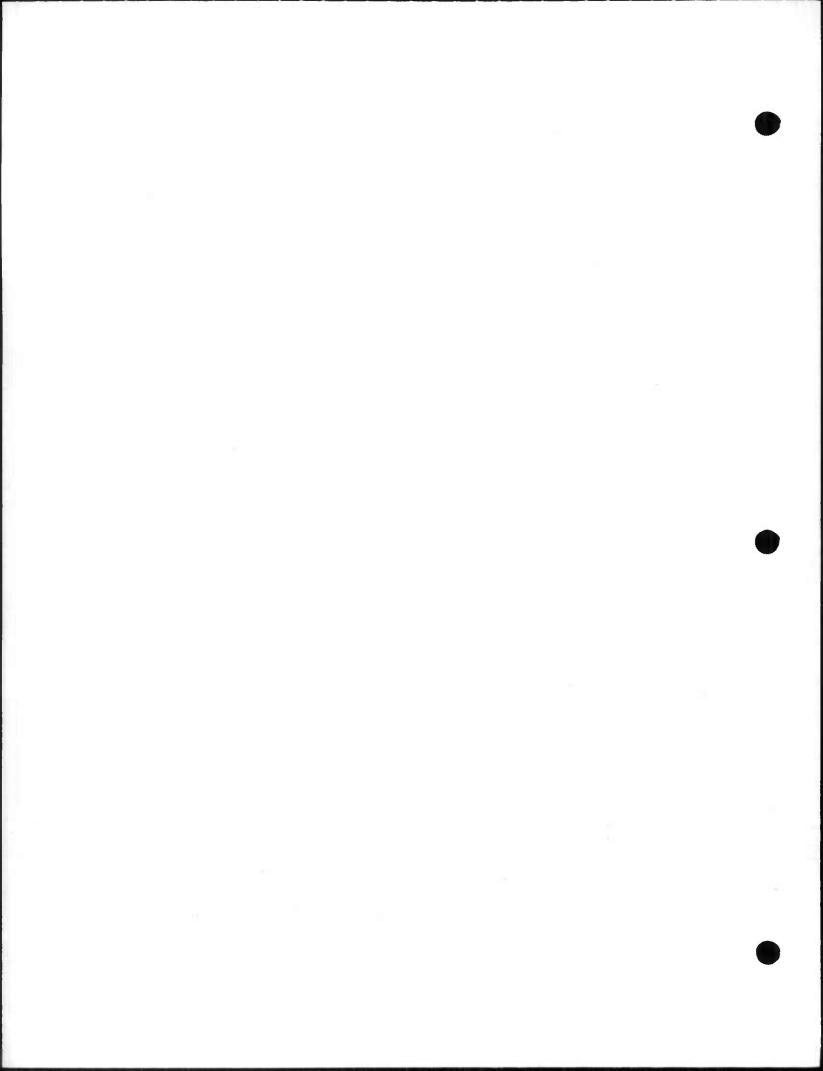
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | TIEGIOTTANI | | | | ICAIE | VI | DLA | 1 1 1 | | REG. NO. | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE C | | | | 3. TIME OF DEATH | |
| - 1 | Elbert G. Manche | | | | | | | August 21, 1995 8:15 | | | 8:15 A M | | | |
| - 9 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. In | est birthday) | IF UNDER 1 | YEAR | IF UNDER | 3 24 HRS. | 7. DATE O | | , 17 | | PLACE (State or Foreign | |
| | 040-05-9248 | 1 🖳 M 2 🗆 F | 87 | YRS. | MONTHS | DAY8 | HOURS | MIN. | (Month, | Day, Year) | | Country | y) | |
| | 9a. FACILITY NAME (If not institution, give st | 42 | 07 | 11.0 | | | | | | 12,190 | | | Connecticut | |
| or . | | | | | 9b. CITY, 1 | OWN (| OR LOCATI | ON OF DE | EATH | | 9c. COU | NTY OF D | EATH | |
| ō l | Potomac Valley Nu | rsing Ho | me | | Rockville Montgomer | | | | | | ery | | | |
| 2 | 10e. STATE 10b. COUNTY | | | T | | | | | | | | | | |
| DIRECTOR | | | | 10c. CI1 | 10c. CITY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| | Connecticut Litc | hfield | | | Wins | tec | 11 | | | | | | 1 YES 2 NO | |
| FUNERAL | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | | | 10g. CITIZEN OF WHAT COUN | | | HAT COUNTRY? | |
| ш | 103 Wetmore Avenu | e | | 06098 | | | | | 3 | U.S.A. | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. A | MED 13. WAS DECENDENT OF HISPANIC | | | | | NIC ORIGIN? | | | | - American Indian, White, stc. | |
| | 1 Never Married 2 Married | IF YES, OIVE W | YES 2 | NO | | | ecify Cube | | | | | | | |
| Β¥ | 3 🙀 Widowed 4 🗌 Divorced | | | | The state of the s | | | | | | | | White | |
| 입 | 15. DECEDENT'S EDUC | ATION | 16a. D | 16a. DECEDENT'S US | | UPATK | ON | | 16b, I | KIND OF BUS | INESS/INE | | | |
| E | (Specify only highest grade Elementary/Secondary (0-12) | Completed) College (1-4 or 5 + | | Give kind of v e. Do NOT us | vork done du le retired.) | ring mo | ost of working | ng | | | | | | |
| 4 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 5+ | ' | Law | 37.02 | | | | | Law | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | <u> </u> | | Law | yer | - | | | | | | | | |
| | and the same of th | | | | | | 16, MOT | | | ddle, Maiden S | Surname) | | | |
| ᇤ | George E. Manche | ster | | | | | | | ssie F | | | | | |
| ၉ | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | | r, City or Town | | | | |
| - | Paul B. Manchest | er | 1 | 05 Le | xingt | on | Driv | e Si | llver | Sprin | g,Ma | ryla | nd 20901 | |
| | 20a. METHOD OF DISPOSITION 1 3 Burlel 2 Cremation 3 Remo | - Charles | 20b. PLACE | ANDDATE | OF DISPOSIT | | | | DATE | - | | City or Ton | | |
| | 4 Donation 5 Other (Specify) | Ival Irom State | Cant | ematory or of | ther plece) | ** | | Q / | 126/05 | Lidna | + | Comm | ecticut | |
| | 21. SIONATURE OF FUNERAL SERVICE LIC | ENSEE | 1 Cent | ET CE | 22. N/ | AME AP | NO ADDRE | SS OF FA | CILITY | | | 377 | | |
| - 1 | | (I_{Λ}, O) | 1 | | Fra | nci | is J. | Co1 | lins | Funer | al H | ome, | Inc. | |
| | Limothy | Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | | | | | | | | | | |
| ŀ | 23. PART i. Enter the diseases, or e | omplications that | caused tha d | aath. Do n | ot entar th | na mo | da of dyl | ing, suci | h as cardle | ac or reapir | ratory an | rest, | Approximate | |
| | shock, or haart fallure. L IMMEDIATE CAUSE (Final | list Dnly Dna cau | se Dn each lin | a. | | | | | | | | | Intarval Between Onset and Death | |
| | disease or condition | Sa | 4.5 | | 111. | | | | | | | | Oliset and Death | |
| | resulting in death) | I. DUE TO | OR AS A CONSE | COLLENCE OF | or E | | | | | | | | nous | |
| | | | | | | | | | | | | | 1 | |
| CERTIFICATION | Sequentially list conditions, | aspi | 10/m | per | eum | ou | 9 | | | | | | days | |
| Ē | if any, leading to immediate | | | | | | | | | - | | | | |
| 0 | CAUSE (Disease or injury c. difficulty swallowny month | | | | | | | | | | monthy | | | |
| | that initiated events resulting in death) LAST | JEVE TO (| OR AS A CONSE | OUENCE OF | 7): | | | | | | | | | |
| | descriting in death) CAS1 | | | | | | | | | | | | | |
| - 11 | BARY II Other significant on distant | The second second | | | | | | | | | | | | |
| EDICAL | PART II. Other alignment conditions | resulting I | g in tha underlying cause given in Part | | | | Part I. 2 | PERFORMED? | | 24b. | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| 8 1 | malnufition | | | | | | | 1 VES 2 NO | | | OF DEATH? 1 YES 2 NO | | | |
| | chowie osteonyelifis | | | | | | | | | | | | ľ | |
| 2 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN | | | | | | | | | | 10 120 10 10 | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| 잃내 | EXAMINER? | HOSPITAL: | | | OTHER: | | | | | | | | | |
| ٤I | 27. MANNER OF DEATH | 1 Inpetiant 2 I | | _ | | | - | sidence | 6 Other (| | | | | |
| | 1 Natural 5 Pending | 28e. DATE OF (Month, Da | | 28b. TIM | URY | WO | URY AT | | 28d. DESC | RIBE HOW IN | JURY OC | CURED | | |
| à l | 2 Accident Investigation | | | | | | YES 2 | NO | | | | | | |
| a II | 3 Suicide 8 Could not be 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| ۳ ا | 4 Homicide datarmined | | | | | | | | | town, otalo, | | | | |
| ן ב | 29a. CERTIFIER (Check only | IAN: To the heat of a | my knowledge d | eath occurs | d at the time | dete | | illa a | As the same | | | | | |
| COMPLET | | | | | | | | | | | | | AND DESTRUCTION | |
| 3 | | | anniation and/or | HIVERRIGHTON | n, in my opir | non, a | eath occur | ed at the | time, date a | nd place, and | due to th | e cause(s) | and manner as stated. | |
| u II | 296. SIGNATURE AND TITLE OF CERTUTER) 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | (Month, Day, Year) | | | | |
| <u>ו</u> מ | David (| . Mass | an | | | | E | 1239 | 111 | i | DAU | Bust | 22 1995 | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITE | M 27) (Type. | Print) | | | - | | | 7,100 | 10) | ~-/1/1/ | |
| | David A. Bigs | | | | | to | . 1 | J | Rat | hand | 11 | , 1 | 0.00 | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAF | | 74 | reorge | 100 | n No | 4 0 | ואטעו | hesda | Mo | 7, L | 0017 | |
| | AUG 23 1995 | Juli: As | welson Ran | 1.11 | • | | | | | | | | | |
| | 716 9 9 1332 | Juna aru | PURENT VICE | DO: EQ | | | | | | | | | | |
| | | - | | | | | | | | | | | | |



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| | 68760 | |
| | BOX | |
| | P.0. | |
| | RECORDS, | |
| | OF VITAL | |
| | DIVISION | |

| | 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF H | | MENTAL HYGIENI REG. NO. | | |
|---------------|-----------------------------------------------------------------|--------------------------------------------------|--------------------------------------|----------------------|---------------------------------------|--------------------------------------------------|--------------------|-------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | J. (1. L. O.) | DEATH | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Andrew Alexander | Melgard | | | | August 22, | 1995 | |
| | | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | a. BIP | THPLACE (State or Foreign |
| | 214-18-6035 | - M 2 □ F 73 | 3 YRS. | NONTHS DAYS | HOURS MIN. | Oct. 1,192 | | ryland |
| | Sa. FACILITY NAME (If not institution, give street | t and number) | | 9b. CITY, TOWN (| R LOCATION OF DE | | 9c. COUNTY OF | F DEATH |
| OR | 15301 Beaverbrook (| Court #92-2F | Ξ | Silver | Spring | | Montg | omery |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 100 CITY | TOWN OR LOCAL | TON | | | Tana wasan assa |
| | | gomery | | ver Spr | | | | 10d. INSIDE CITY LIMITS? |
| <u></u> | 10e. STREET AND NUMBER | 50mc1 y | 011 | | . ZIP CODE | | 10a CITIZEN O | 1 YES 2 NO |
| FUNERAL | 15301 Beaverbrook (| Court #92-21 | ₹. | | 20906 | | U.S. | DOTE THE TALL |
| N S | | WAS DECEDENT EVER IN | II C ADMED | 13. WAS DEC | | IC ORIGIN? (Specify Yes | or No.— 14. B4 | ACE — American Indian |
| BY F | 1 Never Married 2 Married | FORCES? 1 TYPES | 2 NO | If yes, sp | ecify Cuben, Mexican 2 NO Specify: | , Puerlo Ricen, etc.) | Bi | ack, White, etc. |
| | 3 Wildowed 4 Divorced | 1942-1946 | | | | | | hite |
| COMPLETED | 15. DECEDENT'S EDUCATI (Specify only highest grade con | npleted) | (Give kind of wo life. Do NOT use | rk done during mo | ON st of working | 166. KIND OF BUS | INESS/INDUSTRY | |
| = | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Executi | | | Twode | Associ | ation |
| ₩. | 17. FATHER'S NAME (First, Middle, Last) | 4 | Executi | .ve | 49 MOTHER'S NAS | II ade | | ation |
| | Andrew Melgard | | | | 101-10 | G. Burns | sumame) | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING A | DDRESS (Street a | | oute Number, City or Town | 2. State Zin Code) | 20906 |
| 2 | Madeline A. Melgard | d | | | | t #92-2E S | | 20300 |
| | 20e. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal | 20ь. | PLACE AND DATE OF | DISPOSITION (No | | | CATION — City or | |
| | 4 Donation 5 Other (Specify) | Me | etery, cremetory or other | an Crem | atory 8/ | 23/95 Alex | andria, | Virginia |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | SEE | | 22. NAME AP | ID ADDRESS OF FAC | | | |
| | - Junathus | De Ca | 2 | | | | | ,MD 20901 |
| | 23. PART I. Enter the diseases, or com | pilcations that caused | the death. Do no | | | | | Approximate |
| | ahock, or heart failure. List IMMEDIATE CAUSE (Final | l only one causs on ea | ch line. | | | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | Brain Tumo | or (Astro | ctoma) | | | | 18 Mo. |
| | 1000 | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| N | Sequentially list conditions, b. | <u> </u> | | | | | | |
| AŢ | If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | OUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | |
| | PART ii Other eignificent conditions o | and the time to death be | | | | | | |
| MEDICAL | PART ii. Other algnificant conditions c | ontributing to death bu | it not resulting in | the Underlying | cause given in F | Part I. 24s. WAS AN A PERFORI | | 4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| Ö | | | | | | t YES 2 | NO E | OF DEATH? |
| Σ | DID TOBACCO USE CONTRIB | LITE TO CALISE OF | DEATH VEC | Пиог | LINICEDTAIN | | | 1 YE\$ 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 8. PLACE OF DEATH | | UNCERTAIN | | | |
| SIC | | OSPITAL: | | OTHER: | e 5 CRasidence 8 | □ On (O N - | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | OF 28c, INJ | URY AT | 28d. DESCRIBE HOW IN | JURY OCCURED | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | IULNI | | RK? 'ES 2 NO | | | |
| | 3 Suicide 8 Could not be | 28a. PLACE OF INJURY - building, etc. (Specif | At home, farm, atr | eet, factory, office | | 261. LOCATION (Street ar City or Town, State) | nd Number or Rura | al Route Number, |
| COMPLETED | 4 Homicide determined | | | | | only or rown, ording | | |
| 딥 | 29a. CERTIFIER 1 XCERTIFYINO PHYSICIAN | | | | | | | |
| Š | 2 MEDICAL EXAMINER: O | In the basis of examination | and/or investigation, | in my opinion, d | eath occured at the t | ime, date and place, and | I due to the cause | e(s) and menner as stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIED | 1 serai | tool | 11.2 | 29c, LICENSE NUM | BER | 29d. DATE SIGNE | EO (Month, Day, Year) |
| TO B | Hearge TI | Hongsi | aux. | nu | D12. | 121 | ► 8 - i | 22-45 |
| | 30. NAME AND AODRESS OF PERSON WHO | | | | | | | |
| | George F. Sengstack | k, M.D. 392 | 29 Ferrar | a Drive | Wheato | n,Maryland | 20906 | |
| | 31. DATE FILED (MORITY, DOWN, 16-117) AUG 23 1995 | 32 REGISTRAR'S SIGNA | Rondall. | | | | | |
| | 1100 89 1333 | June 10 miles | - 04 0-00-0 | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, crempton, or removal. IMPORTANT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF I | | MENTA | AL HYGIEN | | | | |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------|---------------------------------------------------------|----------------------------------|---------------------------------|------------|---------------------|--------------------------------------------------------------------|-------|
| | DECEDENT'S NAME (First, Middle, Last) ROSE | 1 | 1ILMAN | | DEPAIN. | 2. DATE | E OF DEATH | AY | YEAR 195 | 3. TIME OF DEAT | гн Ам |
| | 058-22-1322 | 5. 9EX 6. AGE (1) 1 M 2X F 96 | In yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | E OF BIRTH (th. Day, Year) | | 8. BIRTH Country | PLACE (State or Fo | |
| TOR | 99. FACILITY NAME (If not institution, give street Potomac Valley NUT RESIDENCE OF DECEDENT | alley Nursing Center Rockville | | | 9c. COUNTY OF DEATH Montgomery | | | | | | |
| DIRECTOR | 100. STATE 100. COUNTY Maryland Montg | omery | | town or Loca er Spri | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2X | |
| FUNERAL | 10. STREET AND NUMBER 10,000 Brunswick | | | | 7. ZIP CODE 20910 | | | | | THAT COUNTRY? States | |
| B⊀ | | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 K NO | If yes, sp | CENDENT OF HISPA ecity Cuben, Mexic 2 00 NO Speci | an, Puerto | N7 (Specify Yes Rican, etc.) | - T | 14. RACE | — American India, White, etc. | an, |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) | | 16e. DECEDENT'S ((Give kind of w) We. Do NOT use Antiques | ork done during me retired.) | est of working | | . KIND OF BUS | | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | Geater | 18. MOTHER'S NA | | | | 5 | | - |
| BE (| Morris | Sheinma | | | Minnie | | | | Gold | den | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) Paul Sheinman (N | ephew) | | | ale Dr, | | | | | 52 | |
| | 20s. METHOD OF DISPOSITION | 201 | PLACE AND DATE OF | | | HUCK | | CATION — | 208 | | |
| | 1 Burief 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | | tery, crematory or othesapeak | | | | 22 Be1 | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE / | M00827 | | Funeral ist Ave, | Serv | ices, | P.A. | | | |
| | 23.PART I. Enter the diseases, or cor shock, or heert fellure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death) | cerebo N | ascula | es Oh | | | | ratory arr | eat, | Approximatinterval Be Onset and 2 we | Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART ii. Other algnificent conditions | contributing to deeth bu | ut not resulting in | the underlyin | g ceuse given in | Part I. | 24a. WAS AN PERFOR | MED? | | WERE AUTOPSY FI AWAILABLE PRIOR COMPLETION OF C OF DEATH? | AUSE |
| Σ | DID TOBACCO USE CONTRII | BUTE TO CAUSE OF | F DEATH YES | NO [| UNCERTAI | и П | | | | 1 TES 2X) | Ю |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | 8. PLACE OF DEATH | | | | | | | | |
| IXSI | | ☐ Inpatient 2 ☐ ER/Outpa | itlent 3 DOA | | e 5 🗆 Reeldence | | | | | | |
| ВУ РЕ | 1 X Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME INJU | | RK? | 28d. DEŞCRIBE HOW INJURY OCCURED | | | | | |
| | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA MEDICAL EXAMINER: | AN: To the best of my knowle | | | | | | | | and manner ee st | ated. |
| 띪 | 296. BIGNATURE MAD TITLE OF CHITIPIER | 30 | 5/h | 10 | 29c. LICENSE NUI | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | | тн (1164) 27) (Туре, І | Print) | D0113 | | | AU | g. 2 | 1, 1995 | |
| | Walter E. Goozh, N | | | 09 Shor | efield F | Rd, W | heaton | , MD | 209 | 002-1825 | |
| | 31. DATE AUG 23 1995 | 22 REGISTRAT'S SIGNA | TURE | | | | | | | | |

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Pages 1, 2, 3 should

DIRECTOR

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed wirthin z4 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|

2

31. DATE FILED (Month, Day, AUG 22 1995

B.K.S FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 1. DECEOENT'S NAME (First, Middle, Last) 3. TIME OF DEATH VEAD MOHAMMAD -NWAZ AUGUST 20 1995 1045 A 4 SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (S JANUARY 24,61 Country SARGODHA
PAKISTAN 34 DAYS HOURS 1 XM 2 - F VDC 157-90-3015 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH PARK LOT 14251 LIVINGTON ROAD FORT WASHINGTON PRINCE GEORGES RESIDENCE OF DECEDENT 10d. INSIDE CITY LIMITS? 1XXYES 2 NO 10c, CITY, TOWN OR LOCATION VIRGINIA ALEXANDRIA FAIRFAX CO. 10a STREET AND NUMBER 101 ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? PAKISTAN 2723 ARLINGTON DRIVE APT#101 22306 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES XX NO 1 Never Married 2 Married PAKISTANI 3 Widowed 4 Divorced COMPLETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 15. DECEDENT'S EDUCATION (Specify only highest College (1-4 or 5+) Elamentery/Secondary (0-12) CAB DRIVER PRIVATE 12th 17 FATHER'S NAME (First Middle Last) 18 MOTHER'S NAME (First Middle Maiden Surname) CHANDHARY HADAYAT ULLAH BAJWA HAMEEDA BAGUM 19a. INFORMANT'S NAME (Type/Print) 19h MAII ING ADDRESS /Street and Number or Bural Bouts Number City or Town State 7to Code (FATHER) CHUCK #46 N-B; CHANDHARY HADAYAT ULLAH BAJWA SARGODHA, PAKISTANI 20a. METHOD OF DISPOSITION
1 Burial 2 Offmation 3 (X)
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State NAWAZ FAMILY CEMETERY 8-26-95 GUJRAT, PAKISTANI REAL PRINCIPAL PERVICE 22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STREET, N.W. WDC 20011 23. PART I. Enter the diseases, or complications that caused the death. Do not antar tha mode of dying, such se cardiac or reapiratory arrest, alock, or heart failure. Liet only one ceuse on each line. Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final disesse or condition SHOTGUN WOUNDS TO HEAD /PACE & HANDS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated aventa resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?
XX YES 2 NO HOSPITAL:
1 | Inpetiant 2 | ER/Outpetiant 3 | DOA OTHER: PARKING OTHER:
4 □ Nursing Home 5 □ Rasidenca → Other (Specify) 27. MANNER OF DEATH 26a. OATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT 0630 Am 8/20/95 FOUND 1 Netural SUBTEST B 2 Accident Investigation 28e. PLACE OF INJURY - At home, 281. LOCATION (Street and Nu 3 Sulcide 8 Could not be COMPLETED INSIDE Homicide OXON HILL TA-XI 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of read death occurred at the time, date and piece, and due to the cause(s) and marrier se stated. opinion, death occured at the time, data and pleca, and dua to the cause(a) and manner as stated 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE

O.C.M.E

Penn Street, Baltimore, Maryland 21201

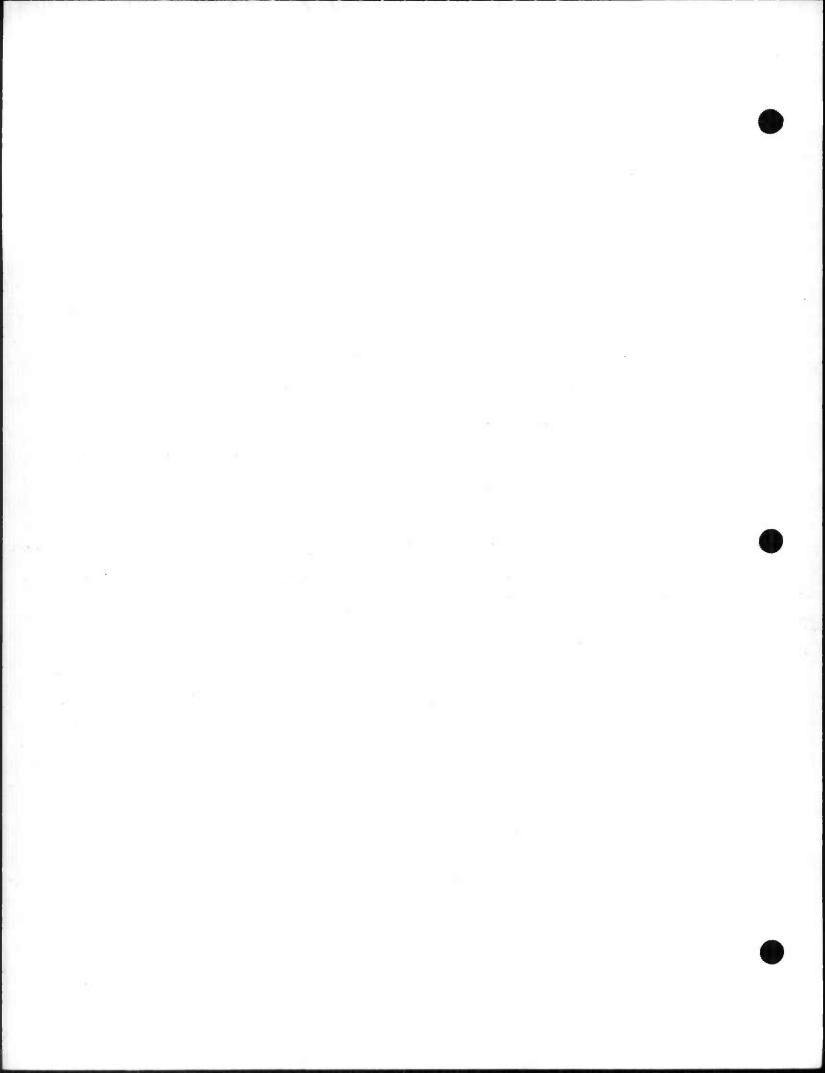
34 RECETTARY CON TURE

► AUGUST 21,1995

| 68760 | |
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| BOX | |
| , P.O. | |
| RECORDS | |
| AL RE | |
| F VITAL RI | |
| | |
| DIVISION | |
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| BALTIMORE, MARYLAND 21215-0020 for death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should onal. | examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | 1. DE 4. SO O O 9a. F/S 10a. S S FRESS 10a. S S MAA 10a. S S S S S S S S S S S S S S S S S S S |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | PLETED BY PHYSICIAN: MEDICAL CERTIFICATION | 23. F IMME disease result if amy cause cause cause cause cause cause and a second result in a second result |

| | 1 - STATE OF MARYL REGISTRAR | AND / DEPARTI | | | MENTAL HYGIEN | | |
|-----|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | Nard | | | 2. DATE OF DEATH | "IR 199" | 3. TIME OF DEATH |
| | | In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 1011 | FITHPLACE (State or Foreign |
| | 075-16-1855 1□ M 2 😿 F | 94 YRS. | DAYS DAYS | HOURS MIN. | (Month, Day, Year) OCT 24 | , a | U_TERSEY |
| | 9a. FACILITY NAME (If not institution, give street end number) | 9 | b. CITY, TOWN C | R LOCATION OF D | | 9c. COUNTY C | |
| | SHADY GROVE HOSPITAL | | ROCKVII | LE | | MONTGO | MERY |
| 7 | 10e. STATE 10b. COUNTY | 10c. CITY, 1 | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| ר ט | MARYLAND MONTGOMERY 104. STREET AND NUMBER | POTO | | ZIP CODE | | | 1 TES 2 NO |
| ב | 8815 HIDDEN HILL LANE | | l lor | 20854 | | | OF WHAT COUNTRY? |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specify Ye | | STATES ACE — American Indian, Black, While, etc. |
| - | 1 | Z X NO | If yes, spe | 2 X NO Specif | on, Puerto Rican, etc.) | | Heck, White, etc. |
| ם | 15. DECEDENT'S EDUCATION | | 1 | | | | WHITE |
| | (Specify only highest grade completed) | (Give kind of work life. Do NOT use n | done during mo | | 16b. KIND OF BU | SINESS/INDUSTR | Y |
| | Elementary/Secondary (0-12) College (1-4 or 5+) | SALES CI | LERK | | RETAIL. | | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | 16. MOTHER'S NA | ME (First, Middle, Meiden | Surneme) | |
| | DAVID DAVIDSON | | | LENA ME | LTZER | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | | | Route Number, City or Tow | | |
| | DORIS MINNEMAN (DAUGHTER) 206. METHOD OF DISPOSITION | | | | -POTOMAC. | | |
| | | PLACE AND DATE OF I | placel | | | CATION — City o | |
| 1 | 21. SIGNAPHWE OF FUNERAL SERVICE LICENSEE | HI. HEDRO | | D ADDRESS OF FA | 8-20 FLU | SHING. | NEW YORK |
| | May 10/4m | 2 | | | | | APELS INC. |
| 7 | 23. PART I. Enter the diseases, or complications that caused | the death. Do not | enter the mod | ROCKVILL | E PIKE-ROC | KVILLE. | MD 20852 |
| | shock, or heart fellure. List only one cause on ea IMMEDIATE CAUSE (Final | ich line. | (| | | matory arrest, | Interval Between Onset and Death |
| | disease or condition resulting in death) | Resbu | 411 | 11 De | 2101110 | | Ariddo |
| Ì | | CONSEQUENCE OF): | 2000 | 7 | THE STATE OF THE S | | Runal |
| | Sequentistiy list conditions, b. Caudia | c au | ufic | euca | - | | sudden |
| | If any, leading to immediate cause. Enter UNDERLYING | CONSEQUENCE OF): | · · · · · · · · · | | 1 1 | Sucae | |
| | CAUSE (Disesse or Injury | CONSEQUENCE OF): | work | M CCC | er my | Jac ne | geary |
| | resulting in death) LAST | | | | / | | |
| | PART II. Other significant conditions contributing to death but | ut not resulting in t | he underlying | ceuse alven in | Part I. 24s, WAS AN | ALITOREY | 24b. WERE AUTOPSY FINDINGS |
| | | | underlying | codeo given in | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| I | | | | | 1 [] YES 2 | NO | OF DEATH7 |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | T TES 2 IDAO |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMMER? 26. PLACE OF DEATH (Check only one) | | | | | | |
| | 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Recidence 8 Other (Specify) | | | | | | |
| | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28c. INJURY AT WORK? | | | | | | |
| | 2 Accident Investigation M 1 YES 2 NO | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY building, atc. (Speci | — At home, ferm, stree fy) | et, lactory, office | | 281. LOCATION (Street of City or Town, State) | and Number or Rui | al Route Number, |
| | 29a. CERTIFIER | | NA VALUE TRAFF | | | 2719/11 | |
| | (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the basis of examination | | | | | | ne(s) and manner as stated |
| 1 | 29). SIGNATURE AND TITUE OF CERTIFIER | - | | 29c. LICENSE NUI | IRER | 294 DATE SIGN | IED (Month One Month |
| | Oto Thumen wo | | | D069 | 59 | Day. | RUT 18. Par |
| 1 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, Pri | nt) | 11 | | 2 | 5/ 17 |
| | EUSA J. MARCHITELL | 10 · 88 | 08 Hus | DENT | u LANE | -700 | FLLT 18, 1995 HDC, NO. |
| | 31. DATE FILED (Month, Day, Year) ALIG 29 1000 | TURE | | | | | 20854 |

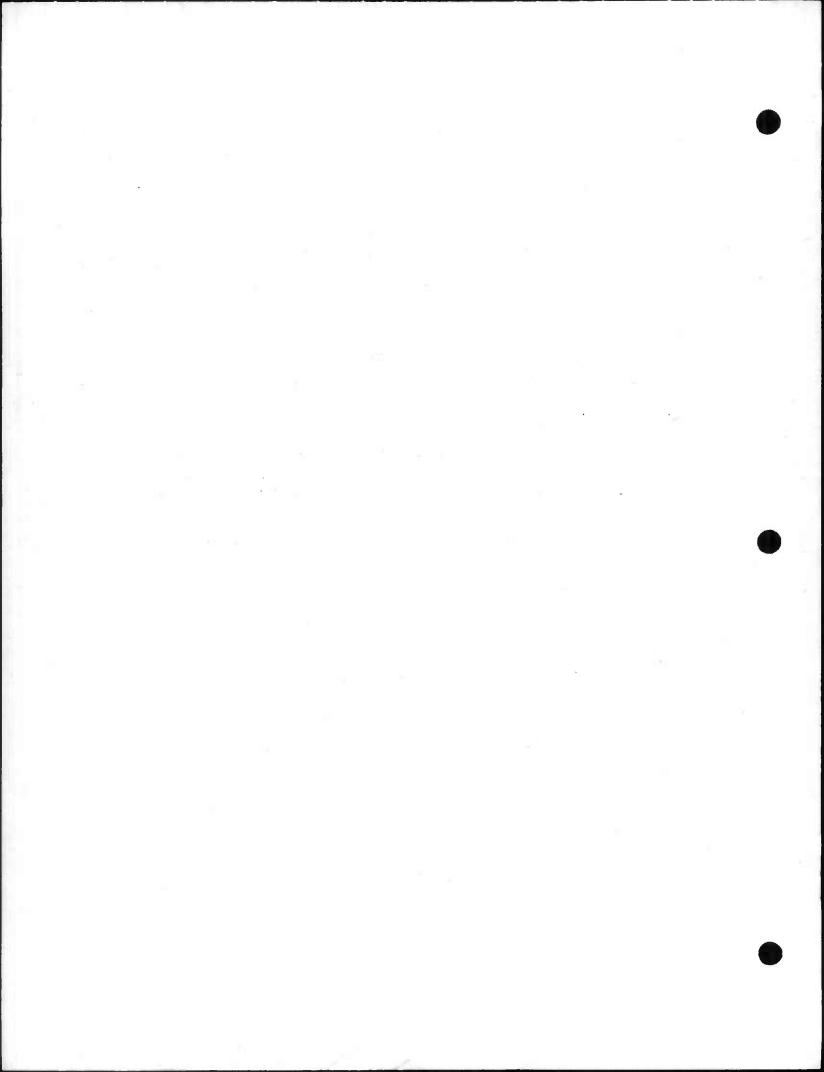


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| 2 | be t | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE CERTIFICATE OF DEATH REGISTRAR REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 3. TIME OF DEATH Q 2. DATE OF DEATH 0900 August 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 230-96-9682 1 - M 2 XXF 34 DAVE July 13, Missouri 1961 as. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Shady Grove Hospital RECTOR Montgomery Rockville RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES XX NO Maryland Frederick Monrovia ā 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4315 Wendy Court 21770 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Mexican, Puerto Rican, etc.)
 U YES 2 HO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5+) 4 Computer Analyst C.D.S.I. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Clarence R. Schneider Barbara Nichols BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert R. Nelson same as #10 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1X Duriel 2 Cremation 3 Re 4 Donation 5 Other (Specify) camplery, cremetory or other piece) Cate of Heaven Camptery August 22, 1995 Silver Spring, Maryland OF FUNERAL SERVICE LICINATI 22. NAME AND ADDRESS OF FACILITY DONALD V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705 23. PART I. Enter the diseases, or com ahock, or heart failure. List applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata only one cause on each line. Onset and Deeth IMMEDIATE CAUSE (Final BREAST CANCER disease or condition_ METASTATIC 30 month reaulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSPOUENCE OF)resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Sinperient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 1 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Matural 5 Pending 1 YES 2 10 NO BY Investigation 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 💆 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner ea stated. 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE AUGUST 19, 1995 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON TREHAN ROCKVILLE MOZDESZ Edmonston 50 W AUG 23 1995 32. REGISTRAR'S SIGNATURE Davidson-Randall

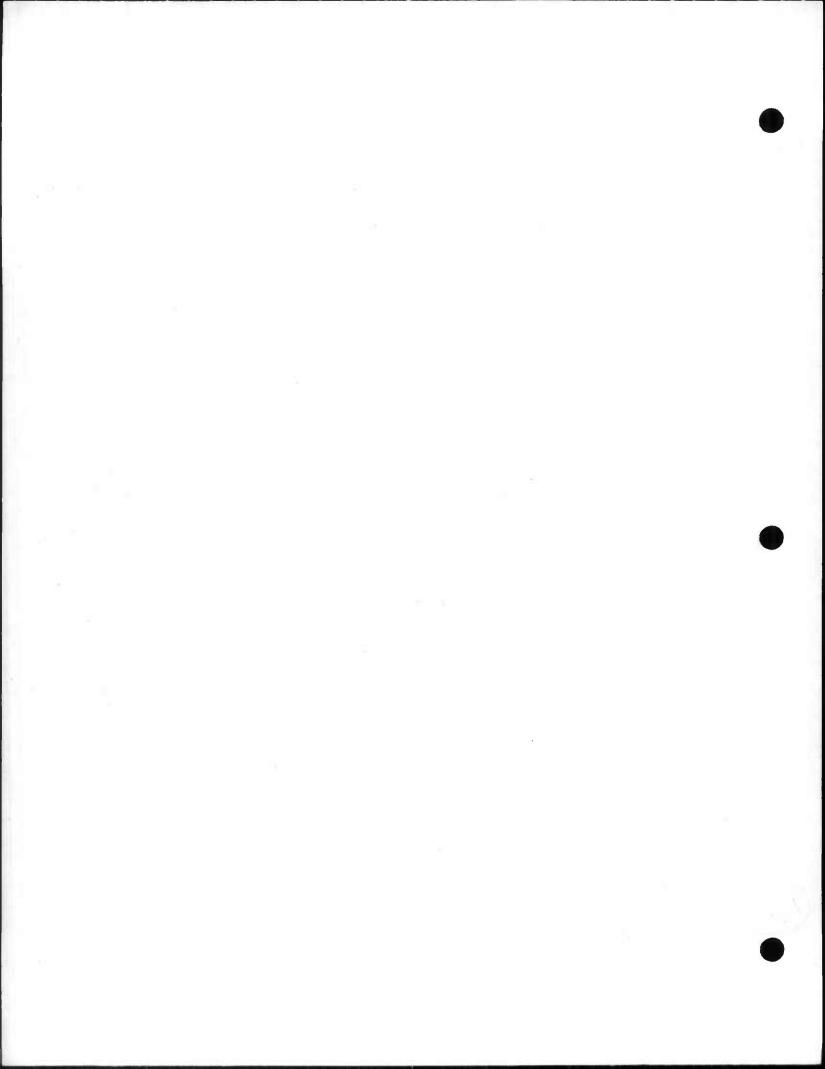


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE OF REGISTRAR | MARYLAND / DEPART | MENT OF HEALTH AND CATE OF DEATH | MENTAL HYGIENE | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------|----------------------------------------|---------------------|--------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Minna Roberts Pacen | | | August 17 | 7, 1995 | 6:17 p w |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | F UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | IPLACE (State or Foreign |
| | 577-22-8241 1 □ M 2 ⊠ F | 82 YRS. | ONTHS DAYS HOURS MIN. | Nov. 18, 1 | | |
| ~ | 9a. FACILITY NAME (If not institution, give street and number) | | b. CITY, TOWN OR LOCATION OF D | EATH | 9c. COUNTY OF D | EATH |
| 힏 | Prince George's Hospital | Center | Cheverly | | Prince (| George's |
| DIRECTOR | 10e. STATE 10b. COUNTY | 10c. CITY, | TOWN OR LOCATION | | | 10d. INSIDE CITY |
| | Maryland Prince George | e's Lanh | nam | | | LIMITS? |
| ¥ | 10e. STREET AND NUMBER | | 10f. ZIP CODE | | 10g. CITIZEN OF V | YHAT COUNTRY? |
| FUNERAL | 7540 Wilhelm Drive | | 20706 | | U.S.A. | |
| 2 | | NT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Mexico | NIC ORIGIN? (Specify Yes o | or No - 14. RACE | — American Indian, |
| BY | | MAR OR DATES | 1 YES 2 NO Specif | | Speci | ty: |
| | 15. DECEDENT'S EDUCATION | 16a, DECEDENT'S US | I BUAL OCCUPATION | 16b. KIND OF BUSH | NESS /INC/JETBY | White |
| <u>.</u> | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 | (Give kind of wor | k done during most of working | Total Kind of Boom | NESS/INDOSTRI | |
| 릴 | 12 | | aintenance Clerk | U.S. Go | vernment | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NA | ME (First, Middle, Maiden Si | urname) | |
| BE | William S. Roberts | | Sarah | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Anita Hardin | | DORESS (Street and Number or Rural | | | |
| _ | 20a. METHOD OF DISPOSITION | | arp Road, Glen | | | |
| | 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State | 20b. PLACE AND DATE OF cemetery, crematory or othe | ninnal | 1. | ATION — City or To | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | Cemetery 8/2 | CILITY | phi, Mar | |
| | ▶) X V () | | Francis Gasch | 's Sons Fun | | |
| 4 | 22 PART I From the district | | 4739 Baltimor | e Ave., Hyat | tsville, | MD 20781 |
| | 23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one car | it caused the death. Do not use on each line. | enter the mode of dying, suc | h as cardiec or reapire | story arrest, | Approximata interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | Onset and Death |
| ł | resulting in death) a. Acute | Ventricular] | Fibrillation | | | 20 min. |
| z | Acute Myocardial Infarction | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | (OR AS A CONSEQUENCE OF): | | | | 20 min. |
| <u>ა</u> | | mic Heart Dise | ease | | | yrs. |
| | regulting in death) I AST | (OR AS A CONSEQUENCE OF): | | | | |
| | | ary Artherosc | | | | yrs. |
| 4 | PART II. Other algorificant conditions contributing to | deeth but not resulting in | the underlying ceuse given in | Part I. 24s, WAS AN AI | | WERE AUTOPSY FINDINGS |
| 음Ⅱ | HTN & HCVD, | Therlip d | ences, Sever | P T YES 2 | EU! | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDIC | Scoliosie COPD | | | | | 1 TES 2 NO |
| ÿ I | DID TOBACCO USE CONTRIBUTE TO CA | | | V 🖾 | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY 28. DATE OF INJURY AT WORK? | | | | | | |
| 2 | 1 YES 2 NO 1 Inpatient 2 27. MANNER OF DEATH 28s. DATE OF | | Nursing Home 5 Residence | | | |
| | 1 Natural 5 Pending | FINJURY 28b. TIME C Pay, Year) INJUR | PF 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HOW INJ | JURY OCCURED | |
| À A | 2 Accident Investigation 3 Suicide 6 Could not be 26s. PLACE Challiding | OF INJURY — At home, farm, atra | | 281. LOCATION (Street and | d Number or Burel B | nute Number |
| | 4 Homicide determined building, | etc. (Specify) | | City or Town, State) | | out wants, |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of | my knowledge, death occurred | it the time data and place, and due | to the reuse/s) and many | or no eteled | |
| | one) 2 MEDICAL EXAMINER: On the basis of a | | | | | and menner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 1 | 29c. LICENSE NUI | | 29d, DATE SIGNED | |
| 2 2 | 101 | Lundagoso | D24720 | | ▶ 8/17/ | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU | | int) | | 0/1// | -//3 |
| | Dr. Ravinder K. Rustagi | | Road, Chever | Ly, MD 2078 | 5-1022 | |
| | 31. DATE FILED (Month, Day, Year) 32 REGISTRA | AR'SISIGNATOBE | | | | |
| | AUG 22 1995 | | | | | |



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31. DATE FILED (Month, Day, Year)
AUG 23 1995

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| | ages 1. | | |
| # MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TA hours after death. Page 6 may be retained by the hospital or attending physician. | # FINEFIAM DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 sho | and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | DITIANT II hem 28 is marked, or them 23 shows any injury, or other traumatic event the medical examiner much he notified at each |
| B | p. | 2 | 3 |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 95 MONT Prector 8:30 Am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 68 78-08-27 WASHINGTON 1 M 2 F DAYS 6500 Riggs Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MANOR YATTSVILLE Hyattsville DIRECTOR MD 20783 RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A N/A WASHINGTON, DC 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 146 THOMAS ST. NW 20001 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. Never Married 2 Married ВҰ Specify: 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12th COSMETOLOGIST PVT. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) MELVIN WAUGH BARBARA PROCTOR BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MELVIN WAUGH/ FATHER 146 THOMAS ST. NW WASHINGTON, DC 20s METHOD OF DISPOSITION
12 Paurisi 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 8-24 20c. LOCATION - City or Town, State MEMORIAL PARK LANDOVER, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J.B. JENKINS FUNERAL HOME
7474 LANDOVER ROAD LANDOVER, MD20785 1811 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximeta interval Batween ahock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death Sh disease or condition reaulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediats cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other significant conditions contributing to death but no the underlying course given in Part I. 24a. WAS AN AUTOPSY
PERPONMED?

1 YES 2 1 TO MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH UNCERTAIN E VES | NO | PHYSICIAN 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER: 1 YES 2 10 ↑ ☐ inpetient 2 ☐ ER/Outpetient 3 ☐ DOA ng Home S I Residence S I Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW BIJURY OCCURED Natural 1 YES 2 NO BY investigation 2 Accident 25e. PLACE OF INJURY -- At home, farm, street, factory, office building, str. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Houte Number, Olly or Tayon, State) COMPLETED 6 Could not be 4 Hamicide 29e. CENTIFIER (Cooch only CERTIFYING PHYSICIAN: To the best of my kno viedge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER igation, in my opinion, death occured at the time, date end place, and due to the cause(a) and manner as stated. BE

29d. DATE SIGNED (Month, Day, Year) DK. Lewis Dennis 20-REGISTRAR'S SIGNATURE



| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician, | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the farmed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLA | ND / DEPAI CERTIF | RTMENT | OF H | DEALTH DEA | AND I | MENTAI | HYGIEN | _ | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------|---------------------------------|---------------------------|-------------|---------------|------------------------|------------------------|--------------------------|-----------|--------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) Mary Peterson | Fortun | o Da | | | | | | 2. DATE MONTH 08 | OF DEATN | | 9 ^{VEAR} | 3. TIME OF DEATN 11:50 a.m |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In | yrs. lest birthday) | IF UNDER | 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE | DF BIRTN , Day, Ybar) | 4 | 8. BIRTN Countr | IPLACE (State or Foreign |
| | 579-28-9881 9a. FACILITY NAME (If not institution, give a | 1 - M 2 XF | 71 | YRS. | | | | | | 0/24 | | S.C | |
| Œ | terminal transfer of the second second | | T | Iomo | _ | | | ION OF DE | EATN | | | INTY OF D | |
| 16 | Manor Care Lard | o Nurs. | rug i | TOME | | arg | 0 | | | | Pri | nce | Georges |
| DIRECTOR | Maryland Prin | ce Geor | ges | | у, то жн с Јрре | | | boro |) | | | | tod. INSIDE CITY LIMITS? 14 YES 2 NO |
| A P | 10e. STREET AND NUMBER | | | | | 101. | . ZIP COD | E | - | | t0g. CIT | IZEN OF W | WHAT COUNTRY? |
| FUNERAL | 10603 Birdie I | ane | | | | | 207 | 72 | | | Uni | ted | States |
| 15 | 11. MARITAL STATUS | 12. WAS DECEDEN | | | t3. | WAS DEC | ENDENT (| OF HISPAN | IIC ORIGIN | ? (Specify Yes | or No- | 14. RACE | — American Indian, |
| ₩ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE V | | | | | | sn, maxicai Specify | n, Puerto F | ican, etc.) | | Specif | |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 1 | 6a. DECEDENT'S (Give kind of | work done o | | | ing | 16b. | KIND OF BU | SINESS/IN | DUSTRY | |
| Ä | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Exam: | , | | | | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | DAdii | LIICI | | | | | over | | t | |
| | Josh Peterson | | | | | | CO1 | rnel | ia I | orake | Sumame) | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | (Street a) | | | | | | o Codel | |
| ٤ | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10603 Birdie Lane Upper Marlboro, MD20772 | | | | | | | | | MD20772 | | | |
| | 20e. METHOD OF DISPOSITION 1 Department of Date 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of Landover, MD.) 20b. PLACE AND DATE OF DISPOSITION (Name of Landover, MD.) 20b. PLACE AND DATE OF DISPOSITION (Name of Landover, MD.) | | | | | | | | | | | | |
| | 21. SIGNATURE-OF FUNERAL SERVICE LIE | ENSEE | | | | | | | | | | | Edwards |
| | · Janice | Edw | ano | le | | | | | | | | | nd, MD. |
| | 23. PART I. Enter the disesses, or shock, or heart fellure. | complications the | t caused t | hs desth. Do | not enter | the mod | de of dy | ing, such | ss cerd | lac or respi | ratory sn | rest, | Approximats |
| | IMMEDIATE CAUSE (Finel | List only one cec | ise on eac | ii iiie. | | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | Metas | tati | c Carc | inon | na c | of S | toma | ach | | | | 7/95 |
| | | | | ONSEQUENCE O | F): | | | | | | | | |
| S | Sequentially list conditions, | Nutro | | ONSEQUENCE O | D. | | | | | | | | 7/95 |
| I K | if any, leading to immediate cause. Enter UNDERLYING | 502 10 | (OH AS A C | ONSEQUENCE O | r): | | | | | | | | |
| E | CAUSE (Disease or Injury that Initiated events | DUE TO | (OR AS A C | ONSEQUENCE O | F): | | | | | | | _ | |
| CERTIFICATION | reaulting in death) LAST | d. | | | | | | | | | | | |
| Ö | PART II. Other significent condition | e contribution to | do ath hut | | la Abrallia | | | | | | | | |
| 18 | Street agricultural condition | a continuoting to | death but | not resulting | in the un | deriying | Ceuse | given in i | Part I. | 24a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICA | | | | | | | | | - | 1 TES 2 | NO | | OF DEATH? |
| | DID TOBACCO USE CONTI | DIRI ITE TO CA | IISE OE | DEATH VI | c \Box A | 10. [| UNIC | EDTAIN | 1957 | | | | 1 TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | NIBUTE TO CA | | PLACE OF DEA | | | UNC | ERTAIN | I A | | | | |
| Sic | EXAMINER? | HOSPITAL: | | | OTHER | 1: | | | a 🗆 au | 40 | | | |
| ΗΥ | 27. MANNER OF GEATN | 28a. OATE OF | INJURY | 28b. TIM | E OF | 28c. INJU | JRY AT | sidence | 8 Other 28d, OEŞi | (Specify) | NJURY OC | CURED | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, D | ny, Year) | INJ | URY | 1 Y | RK? ES 2 | NO | | | | | |
| | 3 Suicide 8 Could not be | 28a. PLACE O | F INJURY - | Al home, farm, | street, facto | ory, office | | | 28f. LOCA | TION (Street a | nd Number | or Rural R | oute Number, |
| COMPLETED | 4 Homicide determined | | | | | | | | Ony o | Siele) | | | |
| IPLI | 29a. CERTIFIER (Check only | | | | | | | | | | | | |
| Ö | one) 2 MEDICAL EXAMINE | | | | | | | | | | | | and manner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | 101 | 7 ~ | 240 | 71 | 7/1 | 29c. LICI | ENSE NUM | BER | 7 | 29d. DAT | E SIGNED | (Month, Day, Year) |
| TO B | (Pa | UXV | 16 | 1/6 | | 7 | D. | 201 | 08 | * | P | ug. | 22, 1995 |
| | 30. NAME AND ADDRESS OF PERSON WN | COMPLETED CAUS | E OF OEAT | H (ITEM 27) (Type. | Print) | | | | | | | | |

14300 Gallant Fox Lane, Bowie Maryland20715



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funeral director, page 5 should

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | = | è | 흕 | 80 |
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| _ | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withlings. | TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely fille | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH August George Benjamin 1995 1940 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) (Morith, Day, Year) Aug. 15, 1908 DAYS 216-12-1993 1XXM 2 F HOURS 87 VRS Virginia 9e. FACILITY NAME (If not inetitution, give street end number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PENINSULA REGIONAL MEDICAL CENTER DIRECTOR SALISBURY WICOMICO RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Wicomico Maryland 817 Mohawk Avenue-Salisbury 1X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 817 Mohawk Av enue 21801 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 □ YES *\[\text{Y} \text{ NO } Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried Specify: Black BY 3 Wildowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8th Custodian Board of Education 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Benjamin Palmer Cecelia Giddeon BE 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joan L. Hayward 817 Mohawk Avenue, Salisbury MD 21801 20a. METHOD OF DISPOSITION
1 🖸 Burlal 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Competery, Crosmotory or other place)

John Wesley Church Cemetery 8/19/95 Mardela Springs MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGH 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home 817 4th St. Pocomoke Maryland 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Prostole - Metortitic **Onset and Death** disesse or condition_ resulting in death) DUE TO (OR AS A CONSEQUE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE DF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury QUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS. AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 Ninpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. (NJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 ND ΒY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town: State) 3 Suicide COMPLETED 8 Could not be 4 Homfclde

29a. CERTIFUEN 1 (CERTIFUING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner ee stated. MEDICAL EXAMINER: Dn the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner es stated.

ANO TITLE OF CENTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) D27820

man mo 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

104 PINE BLUFF RD MARCO, NO SUIR 16

31. DATE FILED (Month, Day, Year) AUG 21

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

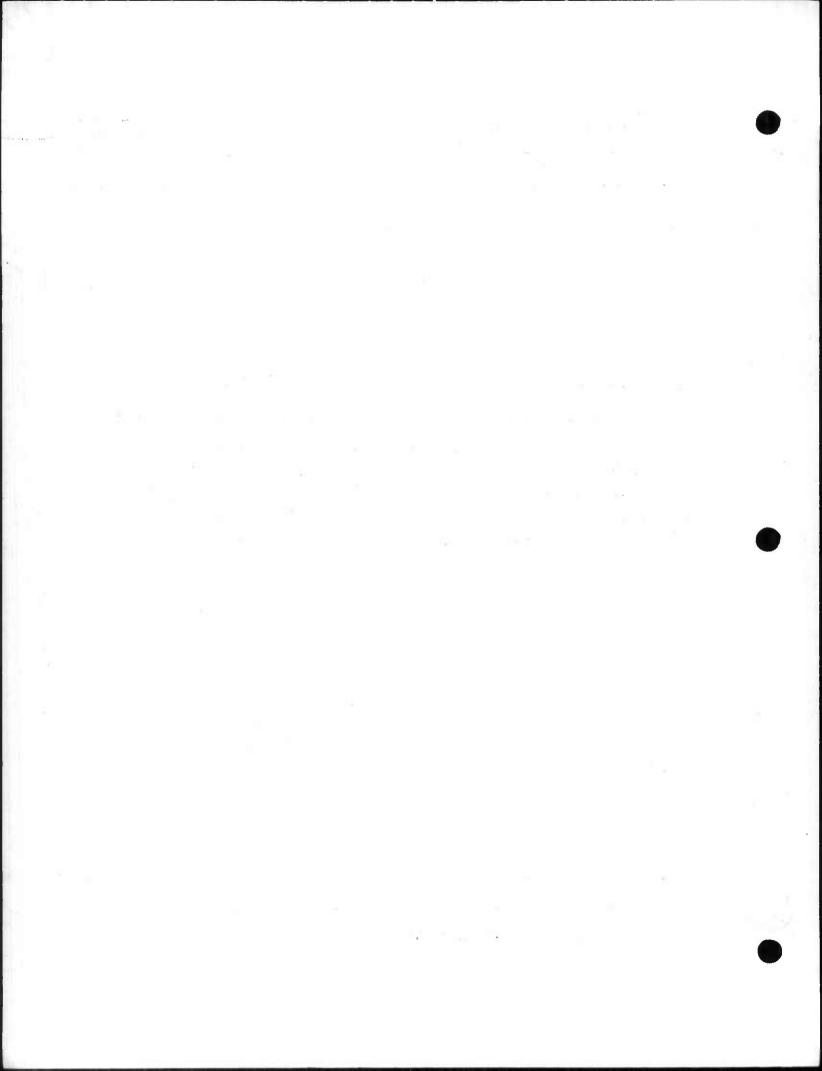
| | 11231377331 | | - IN I III I | CAIL | F DEATI | п | REG. NO. | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) JAMES RICHARD PAT | RICK | | | | | DATE OF DEATH DA | | YEAR | 3. TIME OF DEATH |
| | | | | | | | AUG. 2 | 19 | | 11:45 AM M |
| | 217-12-4766 1x M 2 - F | . AOE (In yrs. lasi | | WONTHS DAY | II GILLERIA E. | | (Month, Day, Year) | 926 | Country | PLACE (State or Foreign () YLAND |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | 9b. CITY, TOV | N OR LOCATION | | | | NTY OF DE | |
| DIRECTOR | 6194 BOSTON CLIFF ROA | EASTON | | | | | TALBOT | | | |
| 2 | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| | MARYLAND TALBOT | | EASTON | | | | | 1 YES 2 X NO | | |
| FUNERAL | 100. STREET AND NUMBER 6194 BOSTON CLIFF ROA | | 101. ZIP CODE 21601 | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| ž | MADITAL STATUS | | | | | | | | | |
| | 1 Nover Married 2 Married FORCES? 1 | FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, atc.) Black, White, atc. | | | | | | | | |
| B | 3 Widowed 4 Divorced | OR DATES | | 10 | res 2 📉 NO | Specify: | | | Specify | WHITE |
| E | 15. DECEDENT'S EDUCATION | 16a, DEC | CEDENT'S U | SUAL OCCUP | ATION | | 16b. KIND OF BUS | INESS/IND | HISTRY | |
| E | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | Ille. | Do NOT use | retired.) | most of working | | | | | E HIGHWAY |
| 립 | 7 | | | EQUIP | MENT | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Lest) | OP: | CRAT | OR | 18 MOTNE | D'S NAME | ADMINIS | | TIOI | N |
| | SAMUEL JAMES PATRICK | | | | | | | | ומ גים | TOP |
| H | 19e. INFORMANT'S NAME (Type/Print) | 106 | MAIL ING A | DDDECC (C) | | | E VIRGII | | | MICK |
| 2 | CHEST COLUMN TO AND A PROPERTY OF THE PROPERTY | - 1 | | | | | | | | 0.7 |
| | JAMES RICHARD PATRICK, | 1 | | | | E., | EASTON, | - | | |
| | 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACEA cometery, cren SPRII | natory or othe | or place) | EMETEI | RY 8 | -4 EAS | | City or You MD | vn, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | . 0 | | | AND ADDRESS | | | | | |
| | NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that c | sused the dea | th. Do no | t enter the | mode of dying | g, auch as | a cardiac or reapir | alory arr | eat, | Approximate |
| | ahock, or heart failure. List only one ceuse IMMEDIATE CAUSE (Final | | | | | | | | | Interval Between Onset and Death |
| - 1 | disease or condition resulting in death) | JC | | De l | CS2 | | | | | 15000 |
| | The state of the s | AS A CONSEO | | | | | | | | 100 |
| z | | | | | | | | | | ĺ |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | AS A CONSEO | UENCE OF): | | | | | | - | |
| 5 | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | |
| 드 | that initiated events DUE TO (OF | AS A CONSEO | UENCE OF): | | | | | - | | |
| 토 | resulting in death) LAST | | | | | | | | | |
| - 11 | DAST II Onber clerities and the | | | | | | | | | |
| EDICAL | PART II. Other algnificent conditions contributing to de | ath but not re | euiting in | the underly | ing ceuse giv | ren in Par | t I. 24s. WAS AN A PERFORM | | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 8 | | | | | | | 1 TYES 2 | ×60 | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | - | 1 YES 2 NO |
| | DID TOBACCO USE CONTRIBUTE TO CAUS | E OF DEAT | H YES | NO | ☐ UNCER | RTAIN [| | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE | OF DEATH | (Check only o | ne) | | | | | |
| Si I | 1 YES 2 NO HOSPITAL: | VOutpatient 3 (| DOA 4 | OTHER: | ome S Resid | dence 8 🗆 | Other (Specify) | | | |
| 둦 | 27. MANNER OF DEATH 28s. DATE OF IN. | | 28b. TIME (| OF 28c. | INJURY AT | | d. DESCRIBE HOW IN | JURY OCC | URED | |
| BY | Natural 5 Pending (Month, Day, | rour) | INJUF | | WORK? | но | | | | |
| - 0 | 3 Suicide 28e. PLACE OF II | IJURY — At hom | ne, farm, str | eet, factory, o | ffice | 281 | t. LOCATION (Street an | d Number | or Rural Ro | oute Number, |
| COMPLETED | 4 Homicide determined building, etc. | (Specify) | | | | | City or Town, State) | | | |
| | 29a. CERTIFIER 14 CERTIFYING BAYOUCIAN. To the head of | Innered at a dis- | | | | | | | | |
| 율 | (Check only one) CERTIFYING PNYSICIAN: To the best of my one) | | | | | | | | | |
| 8 | one) 1/2 MEDICAL EXAMINER: On the basis of exam | ination and/or in | westigstion, | In my opinior | , death occured | at the time | , data and place, and | dua to the | cause(s) | and manner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 | | | 29c. LICENS | SE NUMBER | 3 | 29d. DATE | SIONED (| Month, Day, Year) |
| 10 B | Slink & Ca | XV | 2 | | 1 | 01 | 225 | ▶ 8 | - | 3-71 |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE STEPHEN P. CARNEY, M. I | F DEATH (ITEM | 27) (Type, Pr | rint) Т.Бъттт | ייבעזע ח. | MIIE | EASTON | MT |) 21 | 601 |
| | V | | | 71:W7T | | HOE, | EMSTUN | , MIL | , 21 | 001 |
| | 31. DATE FILED (Month, Day, Year) AIIC - 3 1995 | SIGNATURE | 1.11 | | | | | | | |
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| LECORDS, P.O. BOX 68760 | equires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy | en signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bur |
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31. DATE FILEO (Month, Day, Year)
AUG 22 1995

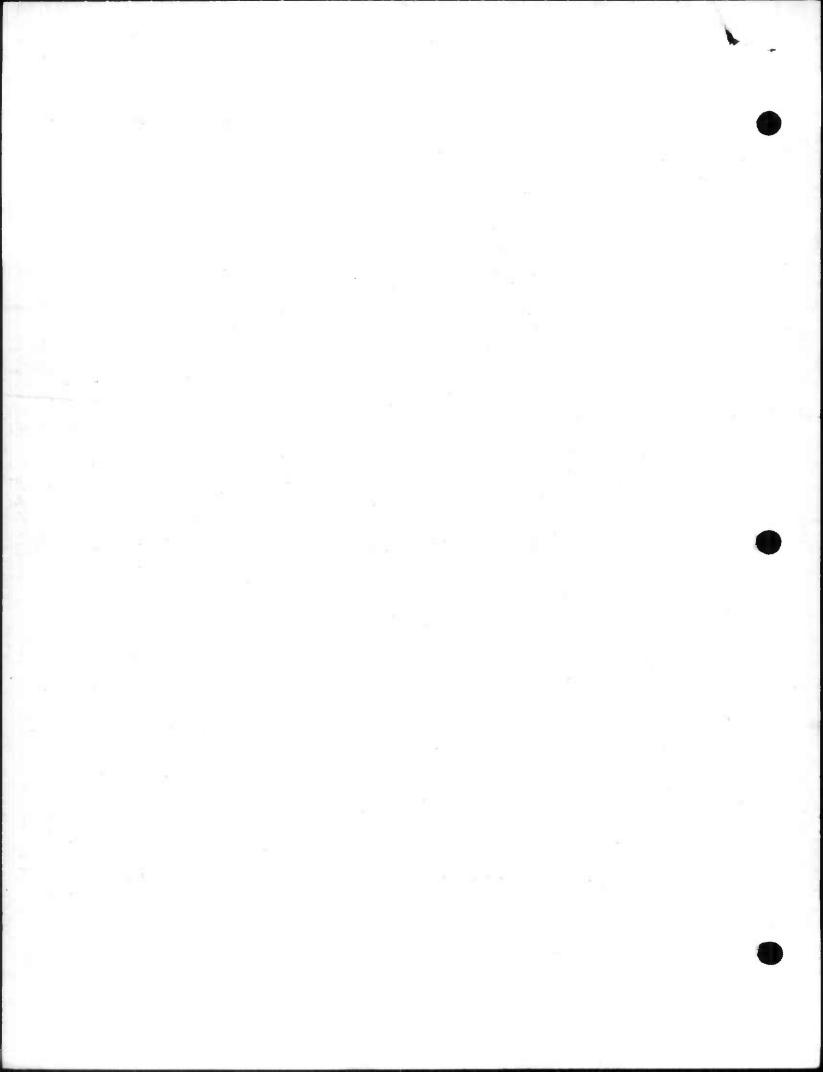
| | | | 1 - STATE REGISTRAR | STATE OF MARY | | | | HEALTH AND F DEATH | MENTAL | HYGIENE REG. NO. | | | |
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| | | | 1. DECEOENT'S NAME (First, Middle, Last) O O V d 4. SOCIAL SECURITY NUMBER | Е. | 7 | DIXI | 24 | | TU94 | 15/ 17 | 11993 | 4 | ME OF DEATH |
| 2 1 | / ₂ 1 | 8 | 577-96-8799 | 1 0X M 2 □ F 33 | (In yrs. les | | ONTHS DAYS | | 7. WATE | 10, 19 | 62 Was | inthpla Shing | gton, D.C. |
| | 3 shou | HO | 3201 Maygreen Ave | eet end number) | | | b. city, town Forest | OR LOCATION OF DI | EATH | | Prince | | |
| | Jes 1, 2 | ECTO | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | | 10c. CITY, | TOWN OR LOC | ATION | | | | 104 | INSIDE CITY |
| | mit. Pa | DIR. | | Georges | | Fore | stvill | | | | | X | YES 2 NO |
| 2 | insit per | ERAL | 3201 Maygreen Ave | ., | | | - 1 | 20747 | | | UNITEI | | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. | the burial-transit permit. Pages 1, 2, 3 should | BY FUN | 11. MARITAL STATUS XX Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ★ 10 If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ YES 2 ★ NO Specify: | | | | | | or No— 14. I | 14. RACE — American Indian, Black, White, etc. Specify. Black | | |
| 1215 r attend | use as | TED | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 16a. DE | CEDENT'S US | SUAL OCCUPATE done during it | TION most of working | 16b. | KIND OF BUSH | NESS/INDUSTI | ₹Y | |
| ID 21 ospital or | detached for once. | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | | mploy | | | | | | | |
| MARYLAND retained by the hospit | 2 4 | BE CO | 17. FATHER'S NAME (First, Middle, Last) EPHESIAN PIXLEY | | | | | 18. MOTHER'S NA LESSIE | WILL | LAMS | | | |
| MA | | 5 | 19a. INFORMANT'S NAME (Type/Print) LESSIE WILLIAMS PI | XLEY | 3 | 201 M | obress (Street | n Ave., F | Route Numb | er, City or Town, tville, | Stere, Zip Code Md | 2074 | 7 |
| BALTIMORE, after death. Page 6 may be | the funeral director, page oval. al examiner must be | | 20a. METHOD OF DISPOSITION Second | 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy, Crangalogy Occupies, place — A DATE 20c. LOCATION — City of Campelegy — A DATE 20c. LOCATION — City of Campelegy — City of C | | | | | | | or Town, 8 | | |
| BALTIMOR er death. Page 6 ma | e funeral din examiner | | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | | | ANDER S. | | | | | |
| BAI after dea | by the fu moval. Ical exa | _ | 23. PART I. Enter the diseases, or co | Hel A. | | 859 | | Penn. | | , S.E. | | 2002 | |
| within 24 hours | pletely tilled in cremation, or re ent, the med | | IMMEDIATE CAUSE (Final | Pagurd | aach iine. | | | | | | itory arrest, | | Approximate interval Between Onset and Death |
| 3OX 68 | by the attending physician and com and Mental Hygiene prior to bunal, or y injury, or other traumatic ev | RTIFICATION | Sequentially list conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | OUE TO (OR AS | | | , | | | | | | |
| DS, P the death | y the ane od Mental injury, d | L CEI | PART II. Other significant conditions | contributing to deeth | but not n | esulting in | the underlyi | Da cause alven in | Part I | 24a, WAS AN AL | IMARKY . | 245 WED | E AUTOPSY FINDINGS |
| RECORD: | pt. of Health and 3 shows any Ir | MEDICAL | | | | | | | _ | PERFORM 1 YES 2 | ED? | COM OF D | LABLE PRIOR TO PLETION OF CAUSE DEATH? YES 2 \(\subseteq \text{NO} \) |
| L RI | 23 per | ICIAN: N | DID TOBACCO USE CONTR | IBUTE TO CAUSE (| | | | | 10 | 01 | | | |
| | State | S | | HOSPITAL: | | - 0 | (Check only one THER: | ome 5 Presidence | 6 ☐ Other | (Specify) | | | |
| OF | with with | ву Рну | 27. MANNER OF DEATH 1 Meturel 5 Pending 2 Accident Investigation | 280. DATE OF INJURY (Month, Day, Year) | | N/ANJUR | OF 26c. IP | NJURY AT N/A VORK? N/A VES 2 NO | | N/A | URY OCCURE | D | |
| DIVISION OR ATTENDING P | after d | TED | 3 Suicide 6 Could not be determined | 26e. PLACE OF INJUR building, atc. (Spe | wolfv) | ne, ferm, stre | et, fectory, off | Ice | | TIÓN (Street end r Town, State) | N/A | ral Route . | Number, |
| | 로인= | COMPLE | | IAN: To the best of my know | | | | | | | | se(e) end | menner se stated. |
| 置 | be filed within | 띪 | 296. BIGNATURE AND TITLE OF CERTIFIER | dufuer 1 | ns | | | D21230 | | | MATE SIG | | |
| 2 | | ٩ | Augusto P. Rodrigu | COMPLETED CAUSE OF DE | OO9 I | Raybur | n Ct., | , Camp Spi | rings | , MD | 20748 | 10/ | M |



| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones. |
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| | TEN | TOR: | 28 |
| | DR A | TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the full be filled within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal. | E |
| | M. | AL C | = |
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| STATE OF MARYLAND / DEPART | MENT OF | HEALTH AND | MENTAL HYGIENE |
|----------------------------|---------|------------|----------------|
| CERTIFIC | CATE OF | DEATH | REG. NO. |

| | 1 - FOR STATE OF MARYL REGISTRAR | AND / DEPARTM | ENT OF H | EALTH AND ME | NTAL HYGIEN | E | | | |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------|--------------------------------------------|------------------|---------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | DATE:OF OEATH | | 3. TIME OF GEATH | | |
| | James Frank Price J | r. | | | E Z | 3 73 | 1/24 | | |
| | | 10000 | NOER 1 YEAR | IF UNDER 24 HRS. 7. | DATE OF BIRTH (Month, Day, Year) | 0. B | RTHPLACE (State or Foreign | | |
| | 212-48-8208 1 \(\overline{\text{TM}} \) M 2 \(\overline{\text{F}} \) 4 9a. FACHLITY NAME (if not institution, give street and number) | 8 YAS. | | | (Month, Day, Year) Oct. 23, | 1946 | Maryland | | |
| œ | | 9b. | | R LOCATION OF DEATH | | 9c. COUNTY C | | | |
| DIRECTOR | 16A Anchor Street | | Wes | tminster | | Car | roll | | |
| Ж | 10e, STATE 10b, COUNTY | 10c. CITY, TO | WN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland Carroll | We | | nster | | | | | |
| RAI | 16A Anchor Street | | | ZIP CODE | | | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN | T. A. A. STATE OF THE STATE OF | | 21157 | | | .A. | | |
| | 1 Never Merried 2 Married FORCES? 1 YES | 2 NO | If yes, spe | ENDENT OF HISPANIC (ocify Cuban, Mexican, P | ORIGIN? (Specify Yea werto Rican, atc.) | 8 | ACE — American Indian, leck, White, alc. | | |
| BY | 3 Widowed 4 Divorced | NIES | 1 YES | 2 NO Specify: | | S | poc//y:White | | |
| | 15. DECEOENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUA (Give kind of work d | one durina mos | N st of working | 16b. KIND OF BUS | SINESS/INDUSTR | Υ | | |
| ا پ | Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT use retir | ed.) | | Vann | -1- | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Lest) | Gro | mer | 40. 1107115010 | Kenn | | | | |
| ŭ | James Frank Price | | | Jessie | | | +h | | |
| 00 | 19a, INFORMANT'S NAME (Type/Print) | 19b. MAILING ADD | RESS (Street a | nd Number or Rural Route | | | | | |
| 임 | Elizabeth Anne Price | | | rg Rd. W | | | | | |
| | | PLACE AND DATE OF DIS | | 1 | | CATION — City o | | | |
| | | rroll Cr | emati | on l | 8/28 Hai | mpstea | d, Md. | | |
| | VIIII | 1 | 254 I | EAST MATI | AFFEETCH! | FR FUN | ERAL HOME | | |
| _ | Many X. Theliper | | WESTI | AINSTER. | MARYLA | ND ZII | 57 | | |
| | 23. PART I. Enter the disease, or complications that caused shock, wheat fellure. List only one cause or enter the cause of enter the cause of enterthing in death) OUE TO (OR AS A | CONSEQUENCE OF: | id | to He | cerdiec or respi | ratory errest, | Approximate Unerval Between Onset and Besti | | |
| ERTIFICATION | cause. Enter UNDERLYING | CONSEQUENCE OF): | | | | | | | |
| C | PART II. Other algnificent conditions contributing to deeth be | ut not resulting in the | underlying | cause given in Par | t I. 24s. WAS AN | AUTOPSY T | 14b. WERE AUTOPSY FRIDWIGS | | |
| <u> </u> | | | , , | • | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| PHYSICIAN: MEDIC, | | | _ | 9 | T YES 2 | 2,40 | OF DEATH? | | |
| z I | DID TOBACCO USE CONTRIBUTE TO CAUSE O | F DEATH YES | NO 🗷 | UNCERTAIN [| 3 | 4.6 | | | |
| <u></u> | 25. WAS CASE REFERRED TO MEDICAL EXAMINERY HOSPITAL: | M. PLACE OF BEATH (Ch | eck only one) 4EPt: | - | | | | | |
| <u>s</u> | 1 YES 2 NO 1 Inpatient 2 ER/Outp | etient 3 DOA 4 D | Nursing Home | 5 ☐ Residence 6 ☐ | | | | | |
| | 1 Natural 1 Pending Bylin Day May | 210. THE CO | 28c INJU | HC V | I. DESCRIBE AOW II | UNITY OCCURED | 10 | | |
| Bá | 2 Accident Investigation 28g PLACE OF INJUNY | - Ayfrighte, form, street, | | F 10 | LOCATION (Storber of | not Montey or Du | MUD. | | |
| | Homicide Sound not be building fits: (Spec | Lougo | - | | CAY OF RIMIN, STREET, | | Vestminster | | |
| COMPLETED | 29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowl | edge, death occurred at I | he lime, deta | | | | . Committee Con | | |
| S | MESICAL EXAMINER: On Mis basis of examination | | | | | | e(s) and manner as stated, | | |
| BEC | 25. SIGNATURE AND TITLE OF CERTIFIER | 1 | T | Ser FORMER HOMBER | 1 | 29d. DATE SIGN | ED (Minth, Day, Year) | | |
| | repord a fues 1 | (1) n | | 4039 | 05 | >27 | Aug 95 | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA | | | | | | / | | |
| | Richard Jones M.D. 200 M 31. DATE FILED (Month, Day, Year) | Memorial | Dr. W | estminst | er, Md. | 2115 | / / | | |
| | AUG 2 8 1995 June Daveler | | | | | | | | |
| | | | | | | | | | |



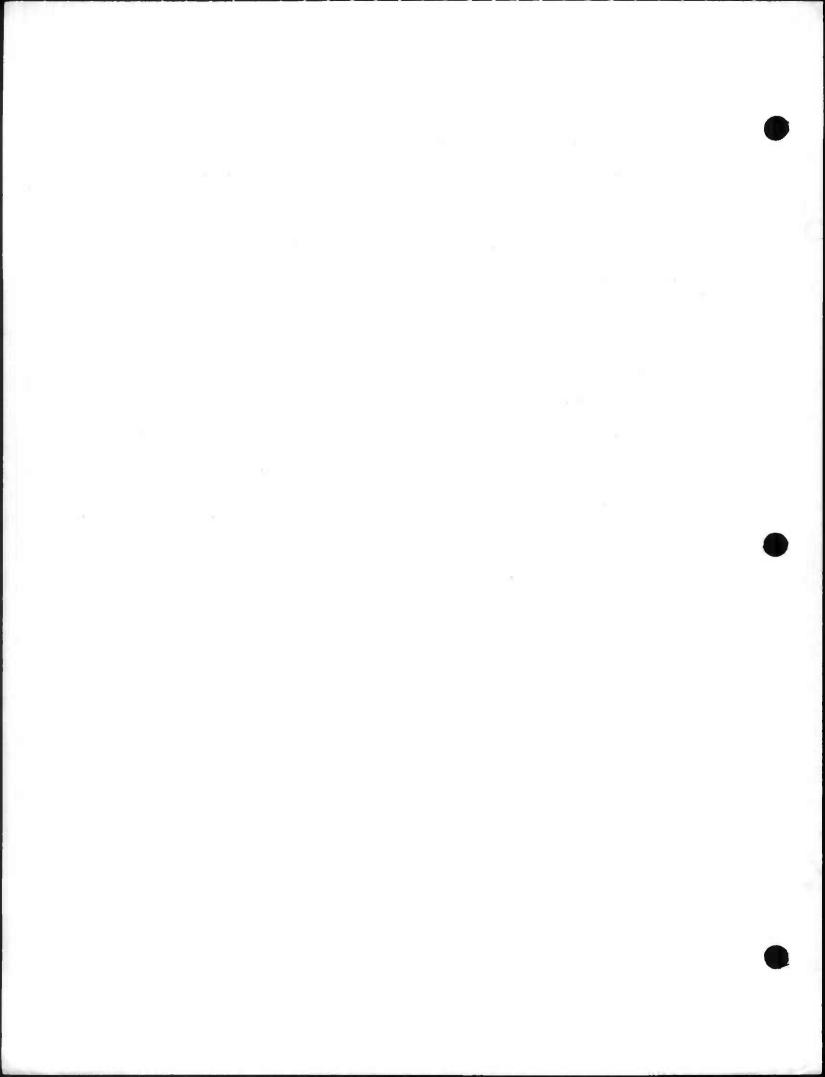
BALTIMORE, MARYLAND 21215-0020
A nours after death. Page 6 may be retained by the hospital or attending physician.

Milled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

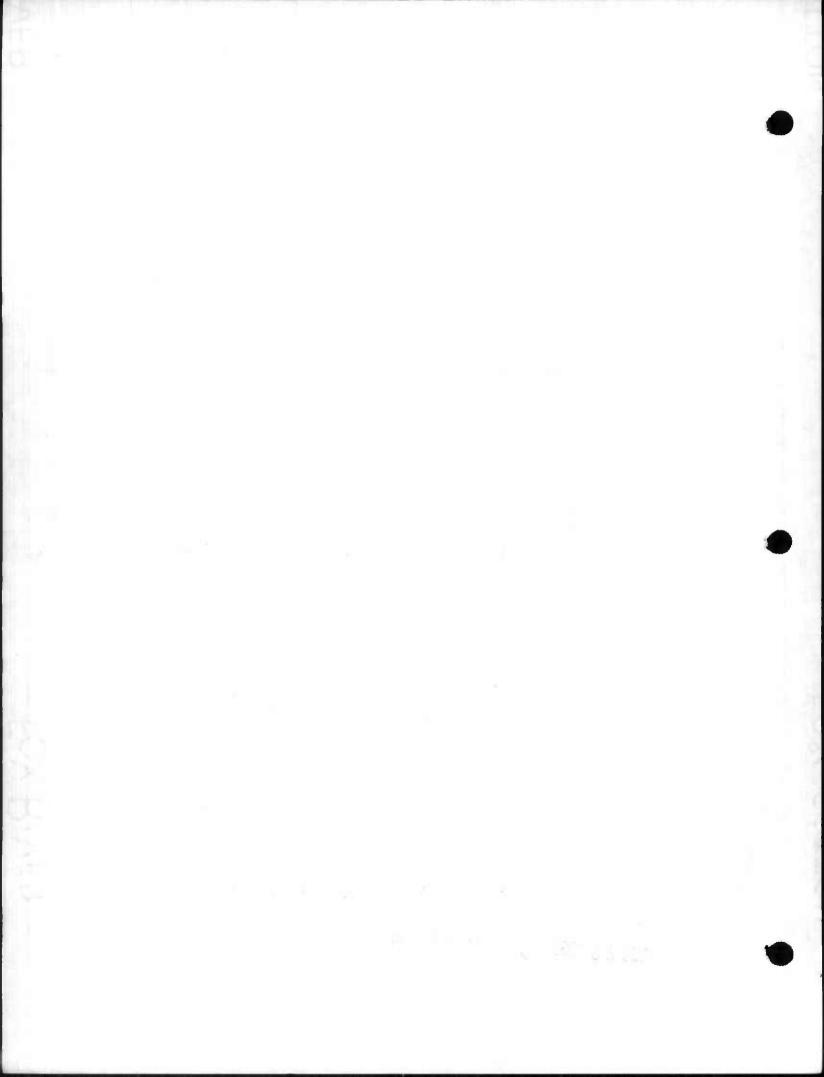
| 6 | 8 | |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be | |
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| | | FOR 1 - STATE REGISTRAR | STATE OF I | MARYI | | | RTMENT | | | | | YGIENI EG. NO. | E | | |
|-----------------------------------------------|------|----------------------------------------------------------|---------------------|-----------|--------------|--------------|---------------|-------------|--------------------------------------------------------------|----------|-----------------------|-------------------|---------------|----------------|-------------------------------------------------------|
| | ġ. | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | 2. DATE OF I | DEATN | | | 3. TIME OF DEATN |
| | | Elizab | eth | E1 1 | len | | PAGE | 1 | | | MONTH | DA | | YEAR | 8: 45 A. M |
| | 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | | (In yrs. les | st birthday) | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE OF B | | 100 | - | PLACE (State or Foreign |
| | | 214-10-3193 | 1 🗌 M 2 💢 F |] 8 | 80 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day | | 21.4 | Countr | γ) |
| | | 9e. FACILITY NAME (If not Institution, give st | reet end number) | | | | 9b. CITY | TOWN C | R LOCATI | | Sept. 8 |), I: | | | yland |
| DIRECTOR | i | Northampton Mano | | ig Ce | ente | r _ | | | ne location of Death sc. County of Death derick Frederick | | | | | | |
| l m | | 10e. STATE 10b. COUNTY | | | | 10c. CIT | Y, TOWN C | OR LOCAT | ION | | | | | | 10d. INSIDE CITY |
| 5 | | Maryland Fr | ederick | | | | Buc | keys | stown | 1 | | | | | LIMITS? |
| | | 10s. STREET AND NUMBER | | | | | | 10f. | ZIP COD | E | | | 10g. CIT | IZEN OF W | VHAT COUNTRY? |
| FUNERAL | | 6912 Michaels Mi | 11 Road | | | | | | 21 | 1717 | | | Ţ | J.S.A | ۸. |
| 5 | | 11. MARITAL STATUS | 12. WAS DECEDEN | TEVER | IN U.S. AR | MED | | | | | NIC ORIGIN? (S | | or No- | 14. RACE | - American Indian, |
| | - 11 | 1 Never Married 2 Merried | FORCES? 1 | | | 40 | | | 2 TYNO | | n, Puerto Ricen v: | , etc.) | | Black Speci | White, etc. |
| BY | | 3 Wildowed 4 Divorced | | | | | | | A. | 400 | , | | | Ореси | White |
| 6 | | 15. DECEDENT'S EDUC (Specify only highest grade | | | | | USUAL Of | | | | 16b. KIN | D OF BUS | INESS/INC | DUSTRY | |
| in in | | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | life. | Do NOT u | se retired.) | auring Trio | 31 O1 WO1101 | ·9 | | | | | |
| ٩ او | ı | 11 | | | Rece | entic | nist | , | | | St | one | prod | ducts | company |
| OMPL COMPL | | 17. FATNER'S NAME (First, Middle, Last) | | | | | | | 18. MOT | NER'S NA | ME (First, Middle | , Melden | Surname) | | |
| BE a | - 1 | John L. O'Hara | | | | | | | | E1 | izabeth | ı Mui | phy | | |
| 10 E | - 14 | 19e, INFORMANT'S NAME (Type/Print) | | | 191 | b. MAILING | ADDRESS | (Street e | nd Number | or Rural | Route Number, C | ity or Town | n, State, Zip | Code) | |
| 2 - | | Susanne E. Blank | | | (| 5912 | Mich | aels | s Mil | L1 R | d., Buc | keys | stown | ı, Mo | 1. 21717 |
| 뮕 | | 20e. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Remo | wal from State | | | | OF DISPOS | ITION (Na | me of | | DATE | 20c. LOC | CATION — | City or To- | wn, State |
| E | | 4 Donation 5 Other (Specify) | | | | matory or o | ner piace) | eter | ~v | Aug | . 30, | 1995 | Fred | deric | k, Maryland |
| | | 21. SIONATURE OF TUNERAL SERVICE LIC | ENSEE | , | | | 22. | NAME AN | DADDRE | SS OF FA | CILITY | | | | |
| examiner must be notified at once. TO BE COM | | > XIlhard, C. | (. 12n) | 160 | M000 | 021 | K | eene | ey ar | nd B | asford | Fune | eral | Home | è |
| 20 | 1 | 23. PART i. Enter the diseases, or c | ompiicationa the | Venusa | | | not enter | 06 I | agt | Chu | rch St. | F | rede | rick, | Md. 21701 |
| Den | -1 | anock, or heart failure. I | ist only one cau | se on e | each iine |). | IDE GIRGI | tire ino | de or uy | ing, suc | n aa cardiac | or reapu | altory an | reat, | Approximata interval Batween |
| 2 | Ш | IMMEDIATE CAUSE (Final disease or condition | 10. | DIAL. | | • | | | | | | | | | Onset and Death |
| E, | H | resulting in death) | | | noni | OUENCE O | | | | | | | | | |
| or other traumatic event, the medical | 1 | _ | | - | | | | 1 | | | | | | | 3 Wroke |
| or other traumatic | ı | Sequentially list conditions, | DUE TO | (OR AS | A CONSEC | DUENCE OF | Clide | m] | | | | | | | - |
| 조 호 | 1 | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | İ |
| 힐匠 | | CAUSE (Disease or injury that initiated events | DUE TO | (OR AS | A CONSEC | DUENCE OF | F): | | | | | | | | - |
| 5 E | | resulting in death) LAST | | | | | | | | | | | | | |
| IL CE | | | | | | | | | | | | | | | |
| | | PART ii. Other aignificant conditions | contributing to | death I | but not r | eaulting | in the un | deriying | cause | given in | Part i. 24e | WAS AN / | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| N N | | thatory of myore | v112, 14 | thro | tus, | 15 | stivy, | d | Oniv | Ox | Ebre- 10 | YES 2 | | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| : ME | | Misim law alliter | t hipe | the | Sich | | . / | / | | | | | | | 1 YES 2 NO |
| 2 Z | 1 | |)r | • | | | | | | | _ | | | | |
| SICIAN | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | | ACE DF D | EATN (Ch | eck only one) | | | | |
| S | ı | 1 YES 2 NO | HOSPITAL: | ER/Out | patient 3 | □ DOA | OTHER | | 5 🗆 Re | sidenca | 6 Other (Spi | ecify) | | | |
| Ä Ä | ľ | 27. MANNER OF DEATN | 26a. DATE OF | | | 26b. TIM | E OF | 28c. INJU | JRY AT | | 28d. DESCRIB | | JURY OC | CURED | |
| marked, BY PH | | 1 Natural 5 Pending 2 Accident Investigation | (Month, D | ey, rear) | | INJ | URY M | 1 Y | ES 2 |] NO | | | | | |
| E B | | 3 Suicide 6 Could not be | 28e. PLACE O | F INJUR | Y — At ho | me, term, : | street, facto | ory, office | | | 281. LOCATION | | nd Number | or Rural A | oute Number, |
| 当 138 | ł | 4 Nomicide determined | building, | etc. (Spe | спуј | | | | | | City or Tov | vn, Stete) | | | |
| MPORTANT: If Item O BE COMPLE | | 29a. CERTIFIER (Check only | IAN: To the heat of | my know | vledne de | ath occur | ad at the " | ma det- | and elec | and de | to the example. | and - | | -4 | |
| M | | (Check only one) 2 MEDICAL EXAMINER | | | | | | | | | | | | | and manner on state of |
| | | 29b. SIONATURE AND TITLE OF CENTER | | | | | , , | | | | | piace, enc | | | |
| E H | | 290. SIGNATURE AND TITLE OF CENTIFIER | | | | | | | 29c. LICE | | MBER | | | | (Month, Day, Year) |
| 2 | - | 20 NAME AND ADDRESS OF STREET | <u> </u> | | | | | | D371 | L78 | | | Aug | g. 29 | , 1995 |
| | | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | | 0:- | | |
| | | Christopher Flemi | ng, M.D. | , 40 | 014 1 | Mount | vi11 | e Ro | d., i | Jeff | erson, | Md. | 2171 | L5 | |
| | | 31. DATE FILED (Month, Day, Year) | 32. RESISTRA | RY SIGN | TURE | and H | 1 | | | | | | | | |
| | | AUG 3 0 1995 | 10 | | | CATA | 7 | | | | | | | | |



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| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | CARROLL JOSEPH POR | TNER | | | | AUGUST 21 | 8:41 p M | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. S | SEX 6. AGE (In yrs. lest i | | | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT Coun | HPLACE (State or Foreign | | | |
| | 213 20 0230 | X M 2 □ F 71 | YRS. | Ins DATS | TOURS MIN. | OCT. 21, 1 | | | | | |
| - | 9a. FACILITY NAME (If not institution, give atreet a | and number) | 9b. | CITY, TOWN OR | LOCATION OF DI | HTA | 9c. COUNTY OF | DEATH | | | |
| 6 | 16151 KELBAUGH RD. | | | | FREDER: | ICK | | | | | |
| E C | 10a. STATE 10b. COUNTY | | 10c. CITY, TO | WN OR LOCATIO | N | | | 10d. INSIDE CITY | | | |
| DIRECTOR | MARYLAND FREDER: | ICK | THURM | ONT | | | | 1 YES 2 X NO | | | |
| A P | 10e. STREET AND NUMBER | | IP CODE | P CODE 10g. CITIZEN OF WHAT COUNT | | | | | | | |
| FUNERAL | 16151 KELBAUGH RD. | | | 21 | .788 | | U.S.A | • | | | |
| 15 | 11. MARITAL STATUS 12. | WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 Y NO | NED D | | | NIC ORIGIN? (Specify Years, Puerto Rican, etc.) | or No — 14. RAC Blac | E — American Indian, ck, White, atc. | | | |
| BY | 3 Widowed 4 Divorced | | | NO Specif | | Spe | chy: HITE | | | | |
| E | 15. DECEDENT'S EDUCATIO | ON 16a. DEC | EDENT'S USU | I AL OCCUPATION | | 16b. KIND OF BUS | SINESS/INDUSTRY | 11111 | | | |
| E. | (Specify only highest grade comp. Elementary/Secondary (0-12) Co | e kind of work Do NOT use rel | done during most ired.) | of working | 0.000 | | | | | | |
| 교 | 7 | | SON | | | CONTRAC | CTOR | | | | |
| once. COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Malden | Surname) | | | | |
| BE at | | ORTNER | | | STELLA | | BAIL | EY | | | |
| 1 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | | | | |
| 2 | MARY JANE PORTNER | | | DISPOSITION (| | THURMONT, N | 1D ZI/88 CATION — City or 1 | Town State | | | |
| unst | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) | | | ther place) Y'S CEM | | 1 | | , MARYLAND | | | |
| 9 | 21. SIGNATURE OF FUNERAL SERVICE LICENS | | | 22. NAME AND | ADDRESS OF FA | CILITY | | , HARLDAND | | | |
| examiner must be notified at once. TO BE COM | ROBERT E. DAILEY & SON, P.A. | | | | | | | | | | |
| | 615 E. MAIN ST., THURMONT, MD 21788 23 PART Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate | | | | | | | | | | |
| E E | | | | | | | | | | | |
| injury, or other traumatic event, the medical | disease or condition | | | | | | | | | | |
| vent, | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| S S | Sequentially list conditions, b | | | | | | | | | | |
| CATION | Sequentienty list conditions, If any, laading to immediate cause, Enter UNDERLYING | | | | | | | | | | |
| 취임 | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| RTIFIC | resulting in deeth) LAST | | | | | | | | | | |
| S S | | | | | | | | | | | |
| - 13 | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | |
| MEDIC | story | Jugana or | | ueru. | · uu | ACLIANT VES | 2 NO | OF DEATH? | | | |
| 60 | Chermata | a (that | 1.0 | | | 1 4 | | 1 YES 2 NO | | | |
| A N | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLA | CE OF DEATH (C | heck only one) | | | | | |
| SICI | | OSPITAL: Inpatient 2 ER/Outpatient 3 | DOA A | THER: | | 6 Other (Specify) | | | | | |
| marked, or BY PHY | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME O | F 28c. INJU | RY AT | 28d. DESCRIBE HOW | INJURY OCCURED | | | | |
| marke BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | | S 2 NO | UK 2 | | | | | |
| <u>=</u> □ | 3 Suicide 6 Could not be | 26e. PLACE OF INJURY — At hor building, etc. (Specify) | me, farm, stree | et, factory, office | | 28t, LOCATION (Street City or Town, State | and Number or Rura | f Route Number, | | | |
| TETE | 4 Homicide determined | | | | | | | | | | |
| ANT: If item 2 | Other biny | i: To the best of my knowledge, dea | ath occurred a | t the time, data a | and place, and du | e to the cause(a) and me | nner as stated. | | | | |
| IMPORTANT: If Item 28 O BE COMPLETE | one) 2 MEDICAL EXAMINER: O | in the basis of examination and/or in | nvestigation, i | n my opinion, de | ath occured at the | e time, data and place, a | nd due to the cause | e(a) and manner as stated. | | | |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | 10. | 1 1 . 0 | Much | 29c. LIGENSE NL | IMBER POR | A THE RESERVE | ED (Month, Day, Year) | | | |
| ₹ P | 30, NAME AND ADDRESS OF PERSON WHO CO | AND STED CAUSE OF STATE | MO | KKMI) | UI |) (0) | 8/23 | /95 | | | |
| | ALAN L. CARROLL, M. | The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa | | | IIRG MD | 21727 | | | | | |
| | 31, DATE FILED (Month, Day, Year) | 32 REGISTRA A SIGNATURE | 1611 | D.IIII IOD | OMG , MD | 6 + I 6 I | | | | | |
| | giug 2 5 1995 | July 10 | - 44-41 | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT (| OF HEALTH AND MENTAL | HYGIENE |
|----------------------------------|----------------------|---------|
| CERTIFICATE | OF DEATH | BEG NO |

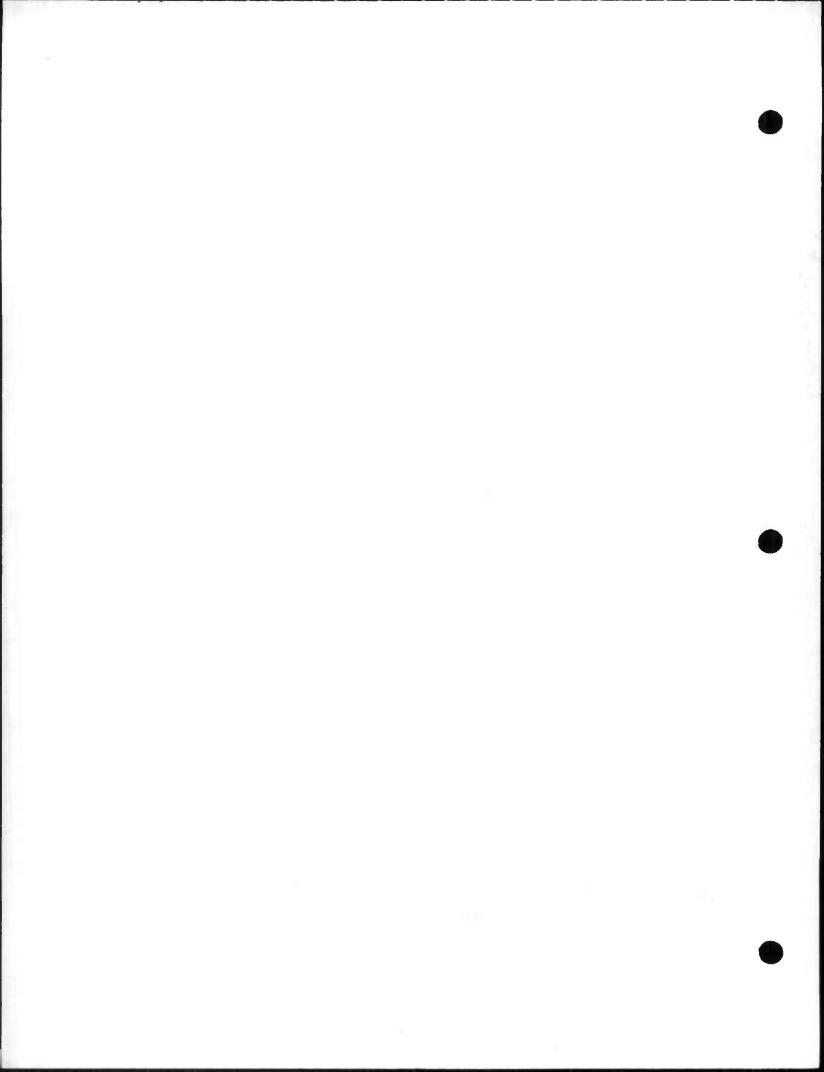
| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO. | | | | | | | | | | |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------|-------------------|-----------------------------------------------------|--------------|------------------------------|---------------------------------------------------------------------------------|---------------------------------------------|---------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) HARRY | | PLATT | | | MONTI | OF DEATH | AV . | VEAR | 3. TIME OF DEATH 9:40PM M | |
| | 213-34-7443 | 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 💢 M 2 🗆 F 7 9 YRS. MONTHS DAYS HOURS MIN. | | | | | OF BIFTH 1, Day, Year) IL 3, | LACE (State or Foreign | | | |
| TOR | 9a. FACILITY NAME (II not institution, give stre 5901 MONTROSE RESIDENCE OF DECEDENT | MONTROSE ROAD #N307 ROCKVILLE | | | | | | | 90. COUNTY OF DEATH MONTGOMERY | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | ONTGOMERY | | TOWN OR LOCAT | | | | 1 | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | |
| FUNERAL | 100. STREET AND NUMBER 5901 MONTROSE | | | 101 | 20852 | | | STATES | | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DA | 2 XNO | If yes, ap | ENDENT OF HISPA ecity Cuben, Maxic 2 NO Speci | en, Puerto F | ? (Specify Yes | American Indian, White, atc. : : WHITE | | | |
| COMPLETED | (Specify only highest grade or | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | PF BUSINESS/INDUSTRY | | | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | I EGIIN. | ICIAN | 18. MOTHER'S NA | | | | APPI | LIANCES | |
| BE | ZEER PLASKOWSK | | 19b. MAILING | ADDRESS (Street a | M. nd Number or Rural | | RUBINS | | la da l | | |
| 10 | ESTHER PLATT | (WIFE) | | | | | | | | AND 20852 | |
| | ESTHER PLATT (WIFE) 5901 MONTROSE ROAD #N307-ROCKVILLE, MARYLAND 20852 20e, METHOD OF DISPOSITION 1 XBuriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) DATE 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of campitary Crymation of an all of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 | | | | | | | | | | |
| CERTIFICATION | 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) METASTATIC GASTRIC CANCER DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | ISCHEMIC HEART DISEASE DIABETES MELLITUS PERFORMED? 1 □ YES 2 ¥ NO DF | | | | | | | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? YES 2 NO | | | |
| AN | DID TOBACCO USE CONTRIL | | B. PLACE OF DEATH | | UNCERTAI | N 🗆 | | | | | |
| SICI | EXAMINER? | IOSPITAL: | | OTHER: | 5 X Rasidenca | β □ Other | (Spacify) | | | | |
| | 27. MANNER OF DEATH 1 🔀 Netural 5 🗌 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c. INJ | | | CRIBE HOW IF | NURY OCCU | RED | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not ba determined City or Town, State) 28a. PLACE OF INJURY — At home, farm, etreet, factory, office City or Town, State) 28b. LOCATION (Street and Number or Run City or Town, State) | | | | | | | Rural Rou | rte Number, | | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| TO BE | 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. D 20 3 4 7 8/2 24 | | | | | | | Aonth, Day, Year) | | | |
| | JOEL KALMAN, MD - 6111 EXECUTIVE BLVD ROCKVILLE, MARYLAND 20852 JOATE FILER (Month, Day, Your) 32. BEGISTRAR'S SIGNATURE | | | | | | | | | | |
| | 31 DATE FILES (MOOTE, DON, 1997) AUG 25 1995 Jul | in Davelson Rom | dall | | | | | | | | |

9 00

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | HEGISTHAH | | | CERTIF | ICALE | : UF | DEATH | | REG. NO | | | |
|---------------|-------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------|------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------|---------------|------------------------------------------------------------|---------------|-----------------------------|-----------------------------------------------------------|
| - 13 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE O | D | AY | VEAR | 3. TIME OF DEATH |
| | Euspechia J. | Polcari | | | | | | Augu | st 22 | , 199 | 95 | 2:30 P |
| | 4. SOCIAL SECURITY NUMBER | | B. AGE (In yrs. | last birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE C | F BIRTH Day, Year) | | 8. BIRTHP: Country) | LACE (State or Foreign |
| - 8 | 356-14-5406 | 1 🗌 M 2 🔯 F | 70 | YRS. | MONTHS | DAYS | HOURS MIN. | Dec. | 23, 1 | 924 | | issippi |
| | 9a. FACILITY NAME (If not institution, give a | atreet and number) | | | 9b. CITY, | TOWN (| OR LOCATION OF | DEATH | | 9c. COU | NTY OF DE | ATH |
| стов | 9214 Cedarcres | t Drive | | | | Be | thesda | | | Mor | ntgome | erv |
| ឆ្ន | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | v | | 100 017 | V 704010 | | | | | | | |
| DIRE | | | | 10C. CIT | Y, TOWN OR LOCATION | | | | | | IOd. INSIDE CITY LIMITS? | |
| AL D | Maryland Mon | tgomery | | | | | thesda | | | | | YES 2 X NO |
| RA | We are an area months | - D. | | | | 101 | I. ZIP CODE | | | | | IAT COUNTRY? |
| FUNER | 9214 Cedarcrest Drive 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | | | | 20814 | | | | | United States | | |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 | | | | | an, Puerto Ri | ilC ORIGIN? (Specify Yes or No — n, Puerto Rican, atc.) | | | American Indian, White, atc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAI | R OR DATES | | 1 | _ YES | 2 NO Spec | ffy: | | | Specify: | Black |
| G | 15. DECEDENT'S EDU | | 16a. | DECEDENT'S | | | | 16b. | (IND OF BUS | SINESS/INC | | DIACK |
| ᇤ | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | | (Give kind of a life. Do NOT us | vork done d se retired.) | luring mo | ast of working | 4,315 | | | | |
| A | | 4 | | Infar | it Ca | re | | | Se: | lf-En | nploye | ed |
| COMP | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NAME (First, Middle, Malden Surname) | | | | | | | |
| BE | David Alexande | r Callende | er | | Julia Lashley | | | | | | | |
| 9 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | (Street a | and Number or Rura | | | | Code) | |
| F | Steven R. Polca | ari | | 9214 (| Cedar | cre | st Drive | Beth | esda, | Mary | land | 20814 |
| | 20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☒ Cremation 3 ☐ Rem | comi from State | | | | | gust 24, | | _ | | City or Town | |
| | 4 Donation 5 Other (Specify) | | Mon1 | tgomer | y CIE | ≥mat | orium. | inc. | Bet | hesd | a, Ma | ryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Act | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | anock, or neart failure. List only one cause on each line. | | | | | | | | | | | |
| 1 | IMMEDIATE CAUSE (Final disease or condition Trad Channel Materials Burnel C | | | | | | | | | | | |
| | resulting in death) End Stage Metastatic Breast Cancer Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| - | _ | | | | , | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 8 | cause. Enter UNDERLYING | | | | | | | | | | | |
| Ē | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | | |
| | PART II Other significant condition | s contributing to d | anth hut no | e sociales d | - Ab | de abel a c | | | | | | |
| EDICAL | PART II. Other significant conditions contributing to death but not resulting | | | | | in the undarrying cause given in Part I. | | | i. 24a. WAS AN AUTOPSY PERFORMED? 24 | | A | ÆRE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| ă | | | | | | | | _ | YES 2 | K) NO | | OMPLETION OF CAUSE OF DEATH? |
| Σ | DID TORAGE HER ST. | ALDALIES TO THE | | | | | | | | | 1 | ☐ YES 2 X NO |
| AN | DID TOBACCO USE CONTI | KIRNIF LO CAN | | | | | UNCERTA | Ν□ | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | ACE OF DEAT | OTHER | : | | | | | | |
| ₹ | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 E | | | 4 🗆 Numi | ng Hom | e 5 🔀 Residence | _ | | | | |
| | 1 Natural 5 Pending | 26a. DATE OF IN (Month, Day, | | 28b, TJM INJ | E OF URY | - | RK? | 26d. DESC | RIBE HOW IN | JURY OC | CURED | |
| B | 2 Accident Investigation | na. Place or l | AL III IPW | | | | rES 2 NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | building, at | c. (Specify) | nome, tarm, s | Rireet, factory, offica 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | ite Number, | | |
| <u>-</u> | 20a. CERTIFIER . On | | | | | | | | | | | |
| MPL | (Check only CERTIFYING PHYSI | | | | | | | | | | | |
| S | 2 MEDICAL EXAMINE | R: On the basis of axer | nination and/ | or Investigatio | n, In my op | Inlon, de | eath occured at the | 1lme, deta a | nd place, and | due to th | e cause(a) a | nd menner es stated. |
| BE | 290. SIGNATURE AND TITLE OF CERTIFIER | * | | | | | 29c. LICENSE NU | MBER | | 29d, DAT | E SIGNED (M | fonth, Day, Year) |
| 3 | Cuth line | 1- | | | | | D4703 | 4 | | ► A | ugust | 24, 1995 |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | OF DEATH (I | TEM 27) (Type, | Print) | | 1 1 1 1 | | | | 0 | |
| | Jaye Viner, M. | D. Nation | nal Na | aval M | edica | 1 C | enter 1 | Bethes | da, M | ary1 | and | 20889 |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR | S SHONATURE | | | | | | | | | |
| - 1 | AUG 25 1995 A | and an emergen | varial | V | | | | | | | | |



1. DECEDENT'S NAME (First, Middle, Last)

PHAWADEE

FOR STATE REGISTRAR

tt hayasr

AUGUST

17,1995

3. TIME OF DEATH

2:40

BIRTHPLACE (State or Foreign Country)

10d, INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

20906

Approximete Interval Betw

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 X68 2 | NO

Onset and Death

1 YES 2 1 NO

Thailand

MONTGOMERY

Thailand

Spacific

Asian

| LAND 21215-0020 | ttending physician. |
|-----------------|------------------------|
| 2121 | al or after |
| AND | he hospita |
| MARYLAP | etained by the hospit. |
| щĨ | ay be ret: |
| TIMOR | Раде 6 т |
| | ath. |

Pages 1, 2, 3 should

permit. burial-transit 20 SE use ō detached once. 8 notified at page 5 should pe pe must rysician and completely filled in by the funeral director, prior to bunal, cremation, or removal. medical examiner the traumatic event. the attending physician I Mental Hygiene prior to other 1 9 inluny, Health and I Dept. 23 HOSPITAL OR ATTENDING PHYSICIAN: The this certificate h with the State (0 marked. After ti death DIRECTOR: / 28 TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h

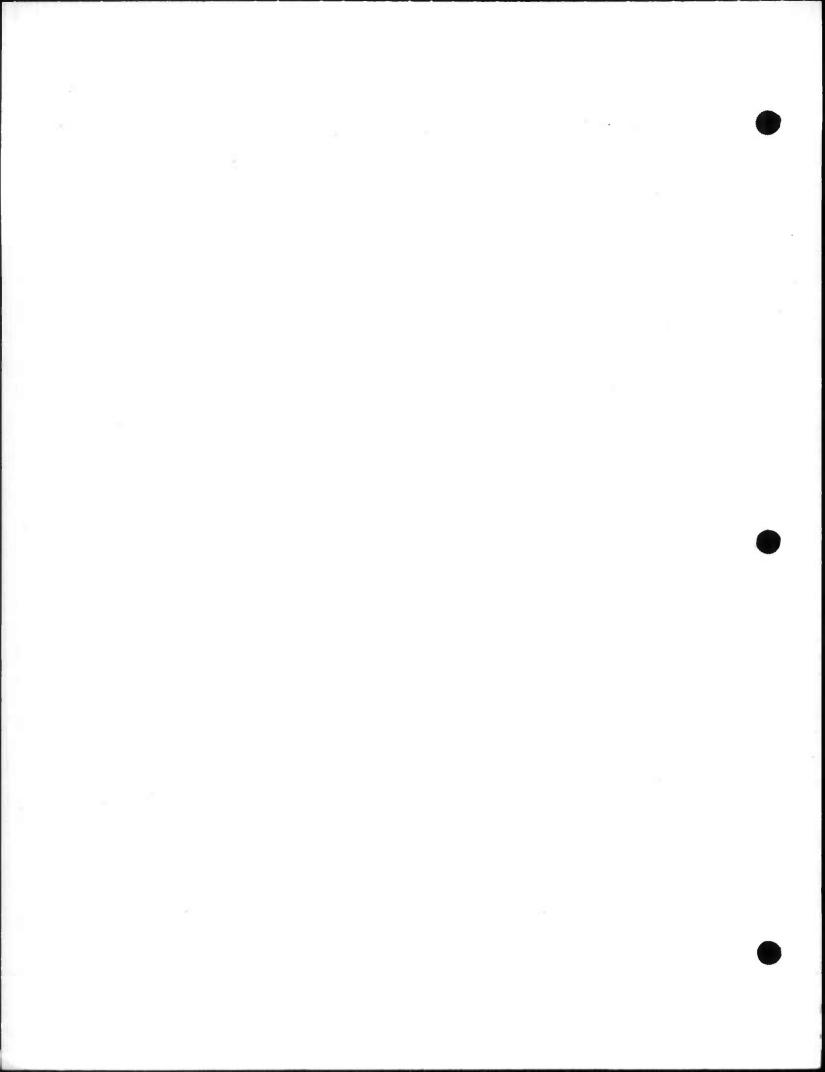
DIVISION OF VITAL RECORDS, P.O. BOX 68760

PITTHAYASRI 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F DAYS 213-15-2502 YRS 15 June 18,1980 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOLY CROSS HOSPITAL SILVER SPRING RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20906 13200 Wilton Oaks Drive 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Ricen, etc.) FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 ☐ YES 2 🔯 NO Specify: BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) П Elementary/Secondary (0-12) College (1-4 or 5+) COMPL EDUCATION 9 Student 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Nopadol Pitthayasri H Pensri Patavanij 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 13200 Wilton Oaks Drive Silver Spring, Maryland Pensri Patavanij 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 🔀 Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Metropolitan Crematory 8/20/95 Alexandria, Virginia 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each light IMMEDIATE CAUSE (Final disease or condition MUTH resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in dasth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | XER/Outpatient 3 | DOA OTHER: 1 X YES 2 | NO 4 Nursing Nome 5 Residence 6 Other (Specify) 26a. DATE OF INJURY (Mgnth, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 26c. INJURY AT 28d. DESCRIBERATION OCOUNTY OCOUNTY 0234 AM 1 Natural 2 Accident BY 26s. PLACE OF INJURY — At home, larm, street, factory, offica building, etc. (Specify) 3 Sulcide 28f. LOCATION /Stree ED 8 Could not be 4 Homicide STEBE determined GEORGIA AVE SILVERSPRINE ET COMPL 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and MEDICAL EXAMINER On the basis of ata restigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, War) BE O.C.ME ▶ AUGUST 18,1995 2 OCOMPLETED CALEBUST DEATH (ITEM 27) (Syppe. Print)

LE JULIA PENN STREET, BALTIMORE, MARYLAND 21201

Julia Division Randall

COLLISION



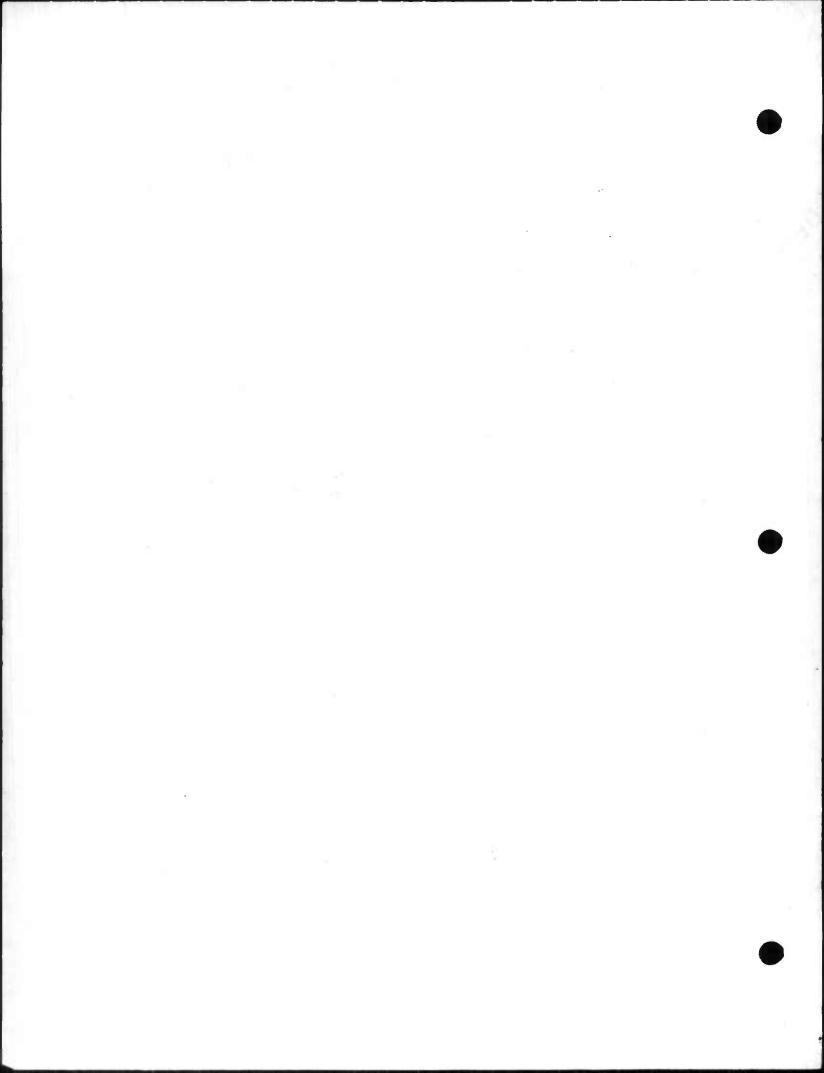
| y the hospital or attend | e detached for use as | | rt once. | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| retained b | 5 should t | | notified a | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attent | TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as | be med within 72 hours aree death with the state bept. Of health and Mental hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| 10 | 5 | De ii | MP | |

| | 0 1 1 #/ 0/0/00 | | 1 | 20 1 | | | | 95 | 27163 | |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------|-------------------------------------------------|--------------------------------------------|---------------------------------------------------------|------------|----------------------|---------------------------------------------|--|
| | 9 mended # / 8/21/95 1 - FOR STATE OF MAR | RYLAND / | DEPARTMEN BILLICAT | IT OF HEALTH AND E OF DEATH | ND MEN | TAL HYGIEN | Oun | ty | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | PA | 111 0 11 | L OF BEATH | 2. D/ | ATE OF DEATH | AY | YEAR | 3. TIME OF DEATH | |
| | 11001 | AGE (In yrs. last | | ER 1 YEAR IF UNDER 24 H | #8. 7. D | TE OF BIRTH | 8 19 | 995 . BIRTHP | PLACE (State or Foreign | |
| | 218-38-9338 1 | 54 | YRS. MONTHS | DAYS HOURS M | | onth, Day, Year) | 1941 | Ma | rvland | |
| c | 9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist H | oeni+ | | ROCKVILL | | | | NTY OF DE | HTA | |
| DIRECTOR | RESIDENCE OF DECEDENT | CSDIC | | | Le | | MO | ntgo | mery. | |
| JIRE | 10a. STATE 10b. COUNTY Maryland Montgomery | - 1 | 10c. CITY, TOWN | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Montgomery 10s. STREET AND NUMBER | 1 | G | ermantown 101. ZIP CODE | 1 | | 10g. CITI | | 1 XYES 2 NO | |
| FUNERAL | 19511 White Saddle | Drive | | 20874 | 1 | | 1 | U.S. | A. | |
| | 11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 1 | YES 2 | ED 13 | WAS DECENDENT OF HI II yes, specify Cuban, M | exican, Puer | IGIN? (Specify Yes | or No- | 14. RACE - Black, | - American Indian, White, atc. | |
| ВУ | 3 ☐ Widowed 4 ☑ Divorced IF YES, GIVE WAR O | OR DATES | | t ☐ YES 2 □XNO S | Specify: | | | Specify B | lack | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DEC (G/M | EDENT'S USUAL | OCCUPATION during most of working | | 16b. KINO OF BUS | SINESS/INC | DUSTRY | | |
| PLE | Elementary/Secondary (0-12) College (1-4 or 5+) 9th Grade | | Labore | | | N. | one | | | |
| SO | 17. FATHER'S NAME (First, Middle, Last) | | | | S NAME (Fir | st, Middle, Maiden | | | | |
| BE | Edward Powell | | | F | lore | nce Y | ound | 3 | | |
| 2 | 196. INFORMANT'S NAME (Type/Print) (Sister) Mrs Lillian Bright | | | SS (Street and Number or R | | | | | 0015 | |
| | 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20C, LOCATION — City or Town, State | | | | | | | | | |
| | 1 K Burlet 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Bushy Park Cemetery 8/24 Cooksville, Md | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 | | | | | | | | | |
| 4 | CHARLER / Mou | use | w | Rockvill | e. M | Id | | | 20030 | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | |
| | disease or condition resulting in death) a. A Cutto MVO Candia (in logo trum) | | | | | | | | | |
| | DUE TO (OR AS A CONSOUENCE OF): | | | | | | | | | |
| NO N | Sequentially list conditions, Due to (or as a conscouence of): | | | | | | | | | |
| CATION | cause. Enter UNDERLYING | | | | | | | | | |
| Ĕ | | AS A CONSEOL | JENCE OF): | | | | | | | |
| CERTIFI | resulting in death) LAST d | | | | | | | | | |
| | PART II. Other significant conditions contributing to deat | th but not rea | uiting in the u | inderlying cause giver | n in Part i. | 24s. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | |
| MEDICAL | | 1 U YES 2 NO OF DEATH? | | | | | | | | |
| M. | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | OF DEATH (Check | conty one) | | | | | | |
| IXSI | t YES 21 NO 1 It Inpetient 2 ERA | | | rsing Home 5 - Residen | ing Home 5 - Residence 8 - Other (Specify) | | | | | |
| | 27. MANNER OF DEATH 28a. DATE OF INJU (Month, Day. Ye. | | 26b. TIME OF INJURY | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURED | | | | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | URY — Al hom | e, ferm, street, le | | 261. L | 261. LOCATION (Street and Number or Rural Route Number, | | | | |
| Ш | 4 Homicide determined building, etc. (Specify) City or Town, State) | | | | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) | | | | | | | | | |
| | 2 MEDICAL EXAMINER: On the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of examination of the basis of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of exa | ation and/or im | reatigation, in my | 7 | | lete and place, and | | | | |
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| 임 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF | DEATH STEM | 27) (True (Print) | 100 | 000 | 3 | · · · · · | 7 1 | | |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ithrow

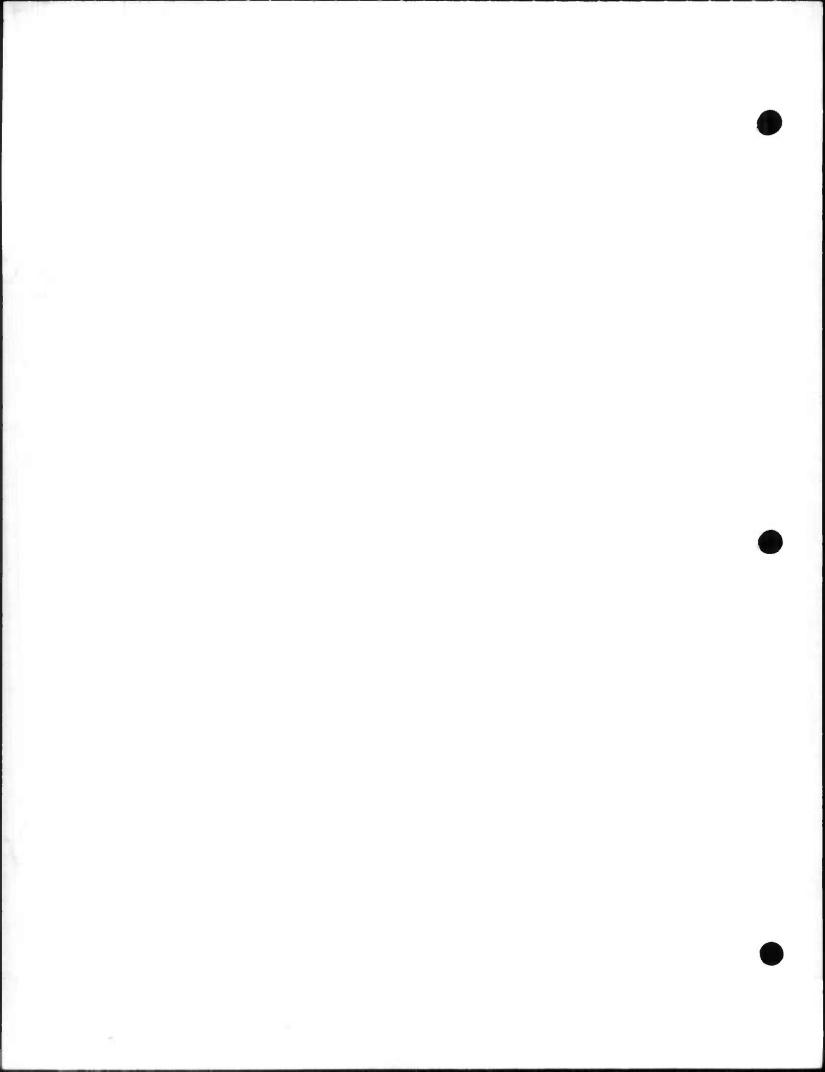
32: REGISTRAR'S SIGNATURE 21 1995

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for | be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. |
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| | 1 - STATE REGISTRAR | STATE OF MA | RYLAND / | DEPAR ERTIF | TMENT (| OF DE | H AND | MENT | HYGIEN REG. NO | IE O | · · | y |
| | 1. DECEDENT'S NAME (First, Middle, Last) Fredder: ck Clark | Fierrou | deric | L C | larke | Pie | rrou | | Gust 1. | 3 199 | 5 ^{YEAR} | 3. TIME OF DEATH 7:25 A |
| | | | AGE (In yrs. les | t birthday) | IF UNDER 1 Y | EAR IF UNI | DER 24 HRS. | 7. DATI | E OF BIRTH oth, Day, Year) | | | HPLACE (State or Foreign ry) |
| | 482-24-6668 9s. FACILITY NAME (If not institution, give stre | et end number) | 66 | THS. | 96. CITY, TO | OWN OR LOCA | ATION OF D | | y 11, | | Neb | oraska |
| DIRECTOR | Perry Point Vetera | | tal | | | rry Po | | | | | Cecil | |
| REC | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR I | LOCATION | | | | | | 10d. INSIDE CITY |
| | Maryland Ceci | 1 | | | Pe | rry Po | | | | 40. 000 | | 1 YES 2 X NO |
| FUNERAL | Perry Point Vetera | ans Hospi | tal | | | 2190 | | | | Transit | | WHAT COUNTRY? States |
| | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT I | YES 2 N | | If yo | s, specify Cu | ban, Mexica | n, Puerto | IN? (Specify Yes | | 14. RACE | E — American Indian, k, White, etc. |
| р ву | 3 Widowed 4 Divorced | 1953-19 | 54 | | | YES 2 XN | O Specif | у: | | | Speci | White |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co | TION ompleted) College (1-4 or 5+) | (G/ | CEDENT'S two kind of a Do NOT us | USUAL OCCL work done duri se retired.) | IPATION ng most of wo | riding | 16 | b. KIND OF BU | SINESS/INC | DUSTRY | |
| MPL | - | 4 | No | ot ap | plical | b1e | | | No | ne | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Arch Pje | erron | | | | 18. M | | | Middle, Melden rginia | , | | |
| TO BE | 19s. INFORMANT'S NAME (Type/Print) | | 198 | . MAILING | ADDRESS (S | treet and Num | | | nber, City or Tow | | | 1 |
| F | Elinor J. Kindelbe | erger | 5 | 480 | Wisco | nsin A | ve., | 325 | , Chev | | | MD 20815 |
| | 1X Burtal 2 Cremetion 3 Removi | al from State | 20b. PLACE A cemetery, cree Ar Lin | metory or o | ther place) Natio | "Augus onal C | t 23 | ,199 ery | 5 Arl | ingto | | wn, state Virginia |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | NSEE . | _ | | 22. NAI | ME AND ADD | RESS OF FA | CILITY | Robert | A. P | damur | rev Funeral |
| _ | Michele & | Sull | | 0348 | Wise | consir | Aver | nue, | Bethe | sda, | MD 2 | 7557 20814 - 3501 |
| - 1 | 23. PART I. Enter the diseases, or con | mpiicetuune (het d | | | | | | | | | | |
| | anock, or neart failure. Lit | at only one cause | on each line | ath. Do i | not anter the | n mode of o | lying, auc | h as car | rdiac or reap | iratory arr | rest, | Approximate Interval Between Onset and Death |
| | ahock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death) a | Respira | tory Fa | ailur | re | n mode of o | lying, auc | h as car | rdiac or reap | iratory an | rest, | |
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| IFICATION | shock, or heart failure. Lift IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | Respira DUE TO (0 Chronic Chronic Chronic | tory Fa | DUENCE OF UCTIV | re P: Ve Puli | | | | | iratory arr | rest, | Interval Between Onset and Death 2 Weeks |
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| L CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions | Respira DUE TO (O Chronic DUE TO (O) Chronic Chronic Contributing to de | TODACO | Duence of Use Duence of Use Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Use Of Us | re P: Ve Puli F: Se | monary | 7 Dise | ease | 24e. WAS AN | AUTOPSY | | Interval Between Onset and Death 2 weeks unknown unknown |
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Midele, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH August 17, 1995 9:00 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 X M 2 - F YRS. 217-34-0454 Dec. 1904 North Korea permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Nursing Center Takoma Park Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring 1 X YES 2 NO FUNERAL 10a STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? nding physician and completely filted in by the funeral director, page 5 should be detached for use as the burial-transit. Hygiene prior to burial, cremation, or removal. 1105 Highland Drive 20910 United States Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerlo Rican, atc.) ☐ YES 2 ☐ NO Specify: BY 3 X Widowed 4 Divorced Specify: Korean COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (8-12) College (1-4 or 5+) 12 4 Business Man Self-Employed 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) T BE Young Kwan Hae Kwan Moon notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Stanley S. Park 39 Woodcrest Ave., Short Hills, New Jersey 07078 2 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must crematory or other place)
Lincoln Cemetery ☐ Donation 5 ☐ Other (Specify). 8/19 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE-LIES examiner 22. NAME AND ADDRESS OF FACILITY hours after death. Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring MD medicai 23. PART i. Enter the disesses, or complications that caused the dasth. Do not anter the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or hasrt feilure. List only one cause on each interval Between Onset and Death IMMEDIATE CAUSE (Final Piratian prolunia the disesse or condition resulting in death) traumatic event, the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF) oke CERTIFICATION Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury the attending physician Mental Hygiene prior to other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY n signed by the Health and N 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMEO? Haud any 1 YES 2 NO been s 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO DE PHYSICIAN: UNCERTAIN has b OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate hours after death with the State HOSPITAL: OTIVER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 -DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Metural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 3 Suicide COMPLETED 8 Could not be 28 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner se stated, (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 309 2 38 NAME AND ADD COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print) MD won, MD 01 Spring 5/100 32. PEGISTRAR'S Julia Davidson Revolate 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

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| NOING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, her death with the state fourth and Mental Manual Avainae and to the burial commercian or removed. | is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certiff | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending in the flad within 22 hours after death with the State Dane of Health and Mental Human | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or oth |

95 27166 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Mary Helen Pearce August 19 1995 5:45a M 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign DAYS 579-18-1449 1 M 2 X F 74 May 4, 1921 Virginia 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5935 Lemay Road Rockville Montgomery RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Montgomery Maryland Rockville 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5935 Lemay Road 20851 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) BY 1 YES 2 X NO Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Payton Rinehart BE Estelle Helena Wooldridge 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jon Hall Pearce 10006 York Drive, Ijamsville, MD 21754 20a. METHOD OF DISPOSITION
1 (X Burlet 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Norbeck Memorial Park 8/23/95 | Olney, Maryland IL SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feiture. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Fine) Onset and Death** disease or condition . Lung cancer reaulting in death) 8 months DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evants reaulting in death) LAST MEDICAL PHYSICIAN:

| PART II. Other algorificant condition | | | | | 24e. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------|--------------|--|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | 28. PLA HOSPITAL: 1 □ Inpetient 2 □ ER/Outpetient | CE OF DEATH (Check | er (Specify) | | | |
| 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. D | | | SCRIBE HOW INJURY OCCU | RED |
| 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) | | | | OCATION (Street and Number or Rural Route Number, fly or Town, State) | |
| | ICIAN: To the best of my knowledge, d | | | | | |

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

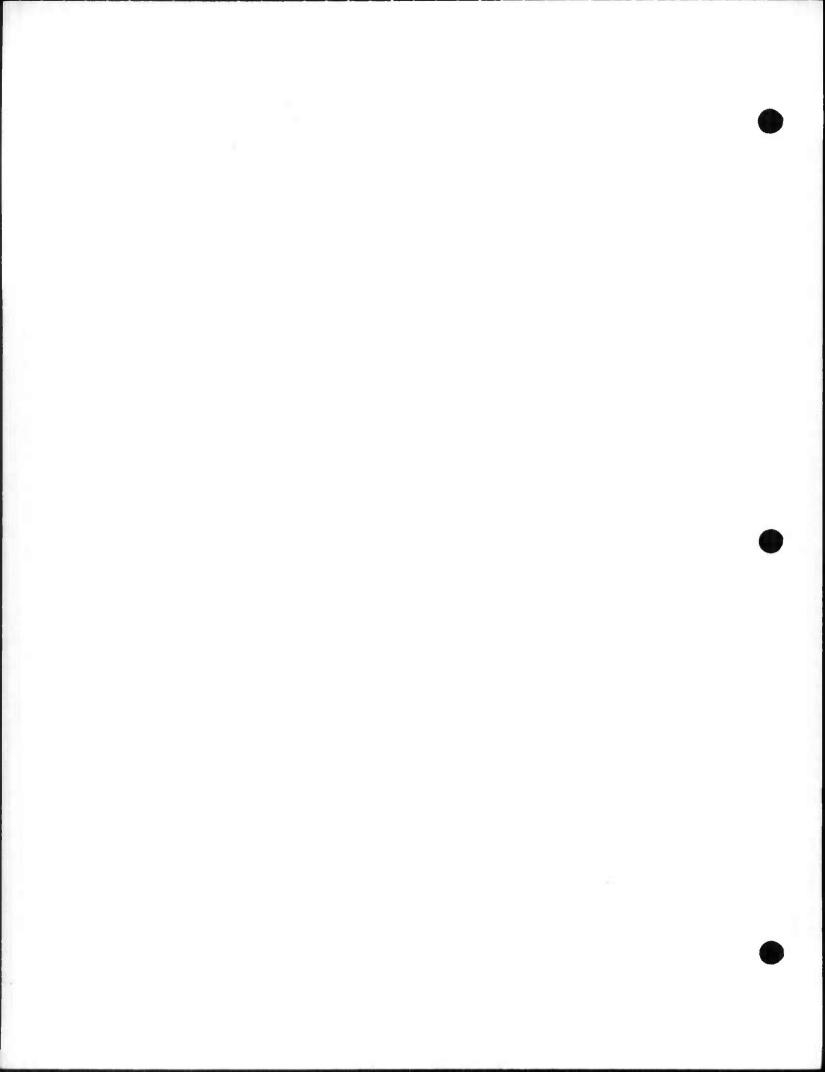
D35635

30. NAME AND ADDRESS OF PARSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Joseph Kaplan, MD 1811 Prince Phillip Drive #327, Olney, MD 20832

31. DATE FILED (Month, Day, Year)
AUG 23 1995

32. REGISTRAR'S SIGNATURE alia davelsor harlall August 21, 1995



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| | ı | | 1. DECEDENT'S NAME (First, Middle, Lest, | | J. | Peace | | | 2. PATE OF HONTH | DEATH DAY | 995 | 3. TIME OF DEATH |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------|------------------------------------------------------|-------------------------------|-----------------------------------------------------------|------------------------|-----------------------------------------|---------------|--------------------------------------------------------------------------------------|
| | Pi | | 4. SOCIAL SECURITY NUMBER 155-62-0785 | 1 M 2 K F | AGE (In yrs. I | | IF UNDER 1 YEAR ONTHS DAYS | | July 1 | 2, 1975 | Count | HPLACE (State or Foreign try) Jersey |
| | 1, 2, 3 should | TOR | 90. FACILITY NAME (If not Institution, give Prince Georges I | | | 1 | Cheve | rly | DEATH | | ince G | Georges |
| | permit, Pages | DIRECTOR | 10a. STATE 10b. COUNT | gomery | | | TOWN OR LOC er Spr | | | | | 10d, INSIDE CITY LIMITS? 1 🖂 YES 2 🗌 NO |
| S | TS# | FUNERAL | 1321 Wembrough Co | ourt | | | 1 | 20905 | | 10g. | USA | WHAT COUNTRY? |
| 21215-0020 al or attending physician | as the burial-transit | ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | YES 2 X | | If yes, i | ECENDENT OF HISPA specify Cuban, Maxie ES 2 NO Spec | an, Puerto Ricar | pecify Yes or No i, etc.) | Spec | E — American Indian, k, White, etc. |
| T 6 | 2 | COMPLETED | 15, DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | UCATION fe completed) College (1-4 or 5 +) | (| ECEDENT'S US Give kind of wor le. Do NOT use i | k done during n | TION nost of working | 16b. Kih | D OF BUSINESS | | |
| | be detached at once. | OMPL | 12 17. FATHER'S NAME (First, Middle, Last) | 3 | | Stud | ent | 16. MOTHER'S N | | College | | |
| MARYLAND retained by the hospit | s should be d notified at o | BE | Blair Peace 19a. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING A | DORESS (Street | Brenda | Peace | | | |
| | De e | 5 | Blair Peace | | 1 | | mbroug | h Court, | Silver | Sprin | g, Mar | |
| 0 0 | e funeral director, page il. examiner must be | | 28s. METHOD OF DISPOSITION Suriel 2 Cremation 3 Rer 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | | rore | rematory or othe St Law | n place) | | 8/22 | | ond, V | irginia |
| BALTIMORE, after death. Page 6 may be | 0 = 0 | | 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | | | | | | | |
| SO within 24 hours | pletely filled in by cremation, or rem ent, the medic | | 23. PART I. Enter the diseases, or shock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death) | Multiple De to (OR.) | on each iin | 0. | | ode of dying, au | ch aa cardlac | or reapiratory | arrest, | Approximate Interval Between Onset and Death |
| S, P.O. BOX 68760 death certificate be executed with | ending physician and I Hygiene prior to bur or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | | EOUENCE OF); | | | | | | |
| RECORDS, requires that the de- | en signed by the of Health and Me hows any Inju | MEDICAL C | PART II. Other algorificant condition | | | | | | | WAS AN AUTOP PERFORMED? YES 2 AND | | . WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| | th the State Dept. of, or Item 23 s | PHYSICIAN: | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | RIBUTE TO CAUSE | | CE OF DEATH | (Check only one | | N 🗆 | | | |
| OF VI HYSICIAN: | this certifica with the St ted, or Ib | HYSI | 1 VES 2 NO | 1 Inpatient 2 ERA | RY | | F 28c. IN | me 5 Residence | _ | E HOW INJURY | OCCURED | |
| | After death | ED BY | Natural | 24. PLACE OF NU. | 1995 my - NO | SV3/ | 1 0 | YES 2 NO | REP N 281. LOCATION | N (Street and Num | hard TK | ed appet |
| | DIRECTOR: hours after item 28 I | 10 H | 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYS | BICIAN To the best of my k | 16 Pd | @ Sur | msvill | and place and du | Go need | ma | y lane | d. |
| HOSPITAL | TO THE FUNERAL be filed within 72 I | COMPL | | ER: On the beals of exemin | | | | death occured at the | time, data and | place, and due t | o the cause(s | |
| 10 TH | THE DE FINE OF THE DE FINE OF THE OF T | TO BE | SO, HAME AND ADDRESS OF PERSON W | odujung | mp | | | 20c. LICENSE NU | 30 | Fu | EUST 2 | (Morth, Day, Year) |
| | | | Augusto P. Rodn | que WID. | 500 | 9 Pay | bum | Et. Co | Sas. 1 | me 2 | v74 | 8 |
| | | | AUG 22 199 | 32. REGISTRARIES | LIGHT RA | rdall | | | V | | | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

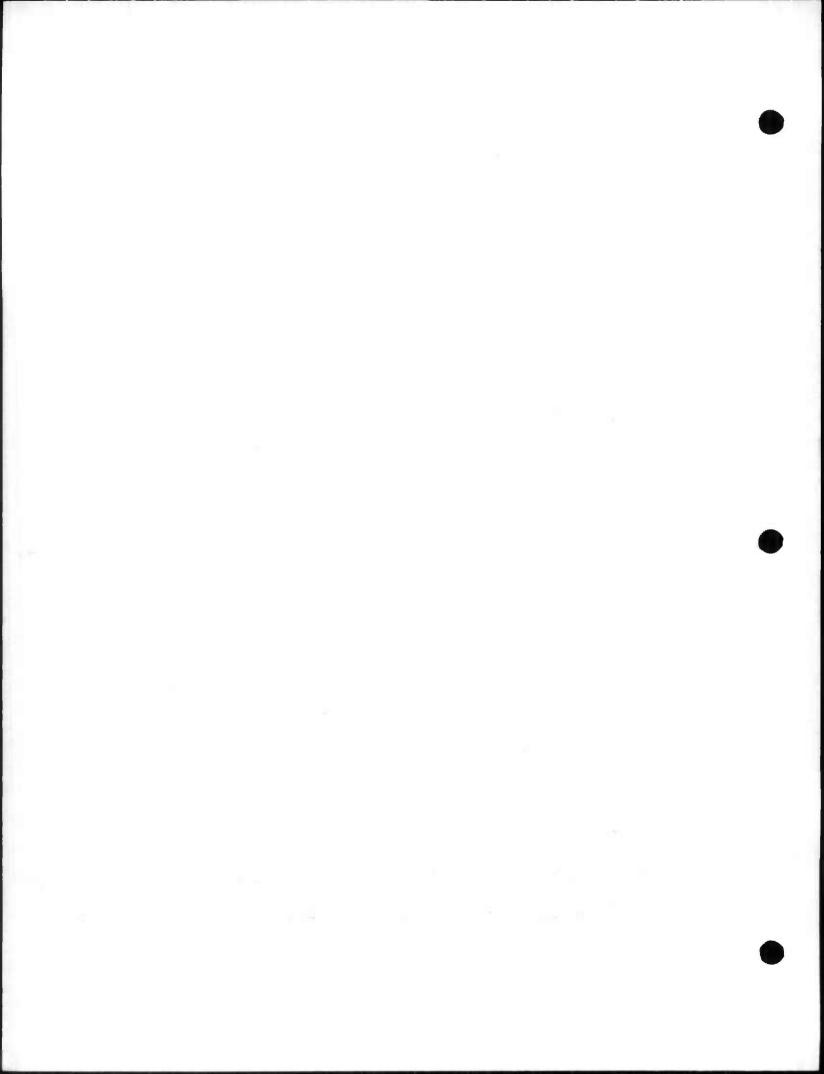
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| E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Planes 1, 2, 3 should | filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | DORTHAY If them 28 is marked or them 24 shows any injury or other transmission evention evention events he settling at any |
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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CEN | RTIFICA | IE OF | DEATH | RE | G. NO. | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------|-----------------|---------------------------------------------------------|-------------------------------|------------------------------|-----------------------------|--------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DE | Day | YEAR | 3. TIME OF DEATH |
| | OLLIE MAE 4. SOCIAL SECURITY NUMBER 5. SEX | PER | | | | AUGUST | | 5 | 10:50 P ₩ |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 \(\text{ M 2} \) | 6. AGE (In yrs. last bir | YRS. MONT | HS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BH (Month, Day, | Year) | Country | |
| | 8a. FACILITY NAME (If not institution, give street and numb | - 70 | 25.43 | OITY TOWN O | R LOCATION OF DE | MAY 31 | | | GINIA |
| Œ | MONTGOMERY GENERAL HOSI | | 90. 0 | | | ATH | | DUNTY OF DE | |
| 6 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | NIGUM | ERY |
| E | | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | MARYLAND MONTGOMER | RY | GA. | ITHERS | | | | | 1 TES 2 NO |
| FUNERAL | 5049 DAMASCUS ROAD | | | 10f | ZIP CODE | 0882 | | | STATES |
| B | 1 Never Married 2 Married FORCES | CEDENT EVER IN U.S. ABMET ? 1 YES 2 NO GIVE WAR OR DATES | 0 | If yes, spi | ENDENT OF HISPAN Icity Cuban, Maxica 2 NO Specify | n, Puerto Rican, | city Yea or No- etc.) | Black, | — American Indian, , White, etc. YWHITE |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a, DECEO | DENT'S USUA | L OCCUPATIO | N of working | 16b. KIND | OF BUSINESS/ | INDUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 | or 5 +) Iffe. Do | NOT use retire | id.) | st or working | | | | |
| AP | 6 0 | НОО | SEKEER | ING | | | HOSPITA | L | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAI | | | | |
| H | WILLIAM AKERS 19a. INFORMANT'S NAME (Type/Print) | 105.44 | AH ING ADDR | 500 (0) | FITA nd Number or Rural F | BETH | SAWYE | RS | |
| 2 | GLENN O. ALLEY | 18 | 538 CH | ERRY | LAUREL L | ANE GA | ITHERS | BURG, N | 1D.20879 |
| | 20a/METHOD OF DISPOSITION 1/\(\sigma\) Burlal 2 \(\sigma\) Cremation 3 \(\sigma\) Removal from Sta 4 \(\sigma\) Donalion 8 \(\sigma\) Other (Specily) | 20b. PLACE AND | DATE OF DIS | POSITION (No | me of | DATE | 20c. LOCATION | — City or Toy | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 0 . | | 22. NAME AN | D ADDRESS OF FAC L H. BAR | NTY FILL | IEDAL II | OME | 20000 |
| | Muriel H. | Barker | / F | 0. B | 0X 5038 | LAYTON | ISVILLE | .MARYL | 20882 _AND |
| | 23. PART i. Enter the diseases, or complication shock, or heart failure. List only on | a that caused the deeth e ceuse on each line. | . Do not en | iter the mo | de of dying, auch | as cardiac o | r reapiratory | arreat, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | ~ ~ ` | | | | | | | Onset and Death |
| ŀ | resulting in death) | POTR: NOM JE TO (OR AS A CONSEQUE | NCE OF | | | | | | TWO YEARS |
| _ | | | ETM | -2016 | C | | | | , , |
| <u>6</u> | | JE TO (OR AS A CONSEQUE | | (17) | > | | | | <u> </u> |
| S | Cause, Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | JE TO (OR AS A CONSEQUE | NCE OF): | | | | | | |
| H | d | | | | | | | | |
| ١ | PART ii. Other aignificant conditions contribution | ng to death but not resu | iting in the | underlying | cause given in | | MAS AN AUTOPS | | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | YES 2 NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | _ - | ~ | | 1 YES 2 NO |
| ž | DID TOBACCO USE CONTRIBUTE TO | CAUSE OF DEATH | YES [| K ON [| UNCERTAIN | | | | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | F DEATH (Che | | | | | | |
| PHYSICIAN: | | t 2 ER/Outpetient 3 I | DOA 4 🗆 I | Nursing Home | 5 Residence | | -,, | | |
| ВУ Р | Netural 5 Pending 2 Accident Investigation | nth, Day, Year) | Ib. TIME OF INJURY | | RK? ES 2 NO | 28d. DEŞCRIBE | HOW INJURY O | CCURED | |
| E | 3 Suicide 6 Could not be 4 Homicide determined | ACE OF INJURY — Al home, iding, etc. (Specify) | farm, street, | lactory, office | | 28f. LOCATION City or Town | (Street and Numi , State) | per or Rural Ro | oute Number, |
| COMPLET | 29e. CERTIFIER (Check only | est of my knowledge, death o | occurred at It | ne time, data | and place, and due | to the cause(s) s | and manner as a | tated. | |
| ŏ. | one) 2 MEDICAL EXAMINER: On the beat | | | | | | | | end manner ea stated. |
| BEC | 296. SIGNATURE AND TITLE DE CERTIFIER | - WE | | | 29c. LICENSE NUM | BER | 29d. D. | ATE SIGNED (| Month, Day, Year) |
| <u>B</u> | 1980 | , | | | D 32F | 35 | ► F | רנטטין | 1 24 1995 |
| - | 30, NAME AND ADDRESS OF PERSON WHO COMPLETED | | | .\ | | | | | |
| | | 18/11 Paine | ~ 11 | :1:6 | Drive | OLN | 154, | NO S | -083> |
| | | istrar's signature | | | | | | | |



| BALTIMORE, MARYLAND 21215-0020 | nurs after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely fifled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhere. hours after death, Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, hours after death with the State Debt, or Health and Mental Hypiene prior to burial, cremation, or removal. |

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COMPLETED

2

t TES 2 NO

6 Could not be

296. SIGNATURE AND TITLE OF CERTIFIER

AUG 23 1995

27. MANNER OF DEATH

Accident

1 Netural

3 Sulcide

4 Homicide

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE IN WITHIN 72 hours at IMPORTANT; If Item 23

DIRECTOR: Att hours after des item 28 Is n

HOSPITAL OR ATTENDING PHYSICIAN: The law

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) <u>Parthenia Tuler ROBINSON</u> 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 1 M 2 DEF YRS 072-20-3455 9a. FACILITY NAME (If not institution, give etreet and number) DIRECTOR Doctors Community Hospital 10h COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION MD Prince George's Seabrook FUNERAL 104 STREET AND NUMBER 9725 Goodluck Rd #3 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Merried BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Give kind at work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Nurses Aid 17. FATHER'S NAME (First, Middle, Last) BE Dorsey Hendricks
19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Numb 2 Kenneth Robinson 20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal from State Donation 6 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE * Symboley Couscox. shock, or heert fellure. List only one cause on each line. **IMMEDIATE CAUSE (Final** disease or condition_ resulting in death) CERTIFICATION Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST MEDICAL PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

| | | | 9! | 5 6 | 27169 |
|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------|------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| EALTH AND I | MENTA | L HYGIEN REG. NO. | _ | | |
| F UNDER 24 HRS. HOURS MIN. R LOCATION OF DI LO.M ON ZIP CODE 2 0 7 0 6 ENDENT OF HISPAI City Cubon, Maxica 2 1 NO Specify | Aug 7. DATE (Mont) I a n EATH | OF DEATH H DA UST 18 OF BHITTH h, Day, Year) 6, 197 | 9c. cou | NOW NTY OF D | Vorice George S 10d. Inside City LIMITS? 1 Yes 2 No WHAT COUNTRY? E—American Indian, K, White, stc. |
| N t of working 18. MOTHER'S NA | | Priva | te | DUSTRY | Black |
| Edna Hi d Number or Rural Ck Rd ne of 1 Park D ADDRESS OF FA Jenkins Landove | #3 AUG 23= GLITY S FU | Seahr Seahr 20c.Loo 95 Lan | ation – | MD city or To | MD |
| to of dying, auchorated to the Paracholam | h aa card | ealth | ratory and | reat, | Approximate Interval Between Onset and Death |
| | | | | | |
| Ceuse given in Part i. 24s. WAS AN PERFORI 1 YES 2 | | | MED? | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 5 - Residence | | r (Specify) | JURY OC | CURED | |
| IK7 ES 2 NO | 20f. LOC | ATION (Street e | nd Number | or Rural F | ioute Number, |

Goodluck Rd #3 239 20b. PLACE AND DATE OF DISPOSITION (Name of Harmony Memorial Park 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Fu 7474 Landover R 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as card DUE TO (OR AS A CONSEQUENCE OF) PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 26. PLACE OF DEATH (Check only one) OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 8/15/95 MN 12 1 YES 2 NO 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCA 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner ee stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Mprith, Day, Year) ▶ 8/19/95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) F. Solouden. MD, 7525 Greenway Center Dr. Greenbelt. NO 20770 32 REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89

JE UNDER 1 YEAR

DAYS

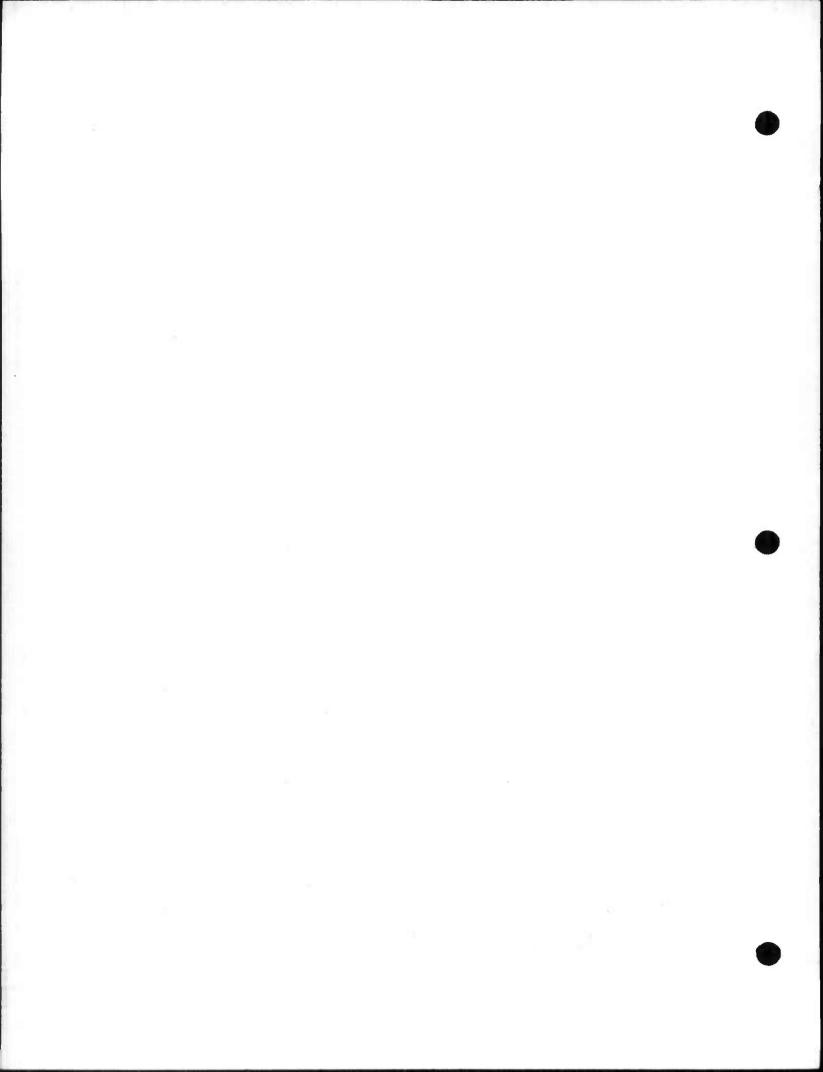
9b. CITY, TOWN OR LOCATION OF DEATH

101. ZIP CODE

13. WAS DECENDENT OF HISPANIC ORIGIN

If yes, specify Cuben, Maxican, Puerto F

Lanham.



BALTIMORE, MARYLAND 21215-0020

| 1 | - | FOR STATE REGISTRAR |
|---|---|---------------------------|
| | | REGISTRAR |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

| | 1 - REGISTRAR | | CI | ERTIFIC | CATE OI | DEATH | RI | EG. NO. | | | |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------|----------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------|-----------------|-----------|------------------------------------------------|---------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | 2. DATE OF D | | | 3. TIME OF DEAT | Ή |
| | LUCIO | | | RA | MIREZ | | AUGUS | ST 19. | 1995 | 0139 | Ам |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. les | st birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | IRTH | 8. BIRTI | HPLACE (State or Fo | |
| | UNAVAILABLE 9a. FACILITY NAME (If not institution, give s | 1 📉 M 2 🗆 F | 21 | YRS. | NONTHS DAYS | OR LOCATION OF DE | | 20 1974 | | DURAS | |
| 5 | 916 NORTH HAMP | | /E | | | ER SPRII | | | ONTG | OMERY | |
| 5 | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT | Y | | 10c, CITY. | TOWN OR LOC | ATION | | | | 10d. INSIDE CITY | , |
| | | GOMERY | | | VER SP | | | | | LIMITS? | |
| FUNE | 916 NORTH HAMPTO | N DRIVE | | | | 20903 | | | ONDURA | WHAT COUNTRY? | |
| 101 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | YES 2 X | RMED NO | If yea, | ECENDENT OF HISPAP specify Cuban, Maxica ES 2 NO Specifi | n, Puerto Ricen | | 0. | E — American Indi ck, White, atc. SPANIC | en, |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a, Di | ECEDENT'S U | SUAL OCCUPA | TION most of working | 16b. KIN | D OF BUSINESS | /INDUSTRY | | |
| COMPLE | Elementary/Secondary (0-12) 6TH | College (1-4 or 5+ | in | NSTRU | retired.) | | SEI | F EMPL | OYED | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | | | | | ts. MOTHER'S NA | ME (First, Middle | s, Malden Suman | 10) | | |
| | LUCIO RAMIREZ SI | R. | | | | VENTUR | A AMAYA | A MARTI | NES | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | t and Number or Rural | | | | | |
| - | JOSE RAMIREZ | | 3 | 314 SOUTH HAMPTON DR. SILVER SPRING, M | | | | | | | |
| | 20s METHOD OF DISPOSITION 1 Durial 2 Cremetion 3 Rem | novel from State | 20b. PLACE | AND DATE OF | F DISPOSITION | - City or T | | | | | |
| | 4 Donation 5 Other (Specify) | | FAMIL | Y CEM | | | | CAIBA | ATLA | NTIC, HON | DURA |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | - | 276 | | W.H. | BACON FU | NERAL I | HOME IN | С. | | |
| | W.H. | Bacu | 16 | | 3447 | 14TH STR | EET, N.V | WASH | ,D.C. | 20010 | |
| MINICALION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST | b DUE TO | (OR AS A CONSE | EQUENCE OF | : | - and | Ska | 15 h | vund | | |
| | | | | | | | | | | | |
| MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 1 Tes 2 No 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | |
| | DID TOBACCO USE CONT | RIBUTE TO CA | USE OF DEA | ATH YES | ON D | UNCERTAI | N D | | | 7 | |
| THISICIAN. | 25. WAS CASE REFERRED TO MEDICAL | | | | d (Check only or | | | | | | |
| | EXAMINER? | HOSPITAL: | ER/Outpatient | | OTHER: | ome 8X Rasidenca | 8 Other (Sc | ecify) | | | |
| | 27. MANNER OF DEATH | 28a, DATE OF | INJURY | 28b. TIME | OF 28c. | NJURY AT | | BE HOW INJURY | OCCURED | | |
| | 1 Netural 5 Pending | 9-1 | 9-95 | 013 | Ø | WORK? YES 2 NO | Subje | ect sh | of 1 | Struck | ed |
| - 1 | 2 Accident Investigation 3 Suicide 6 Could not be | 28a. PLACE O | F INJURY — At h | iome, ferm, si | treet, factory, office 28f. LOCATION (Street and Number or Bural Boute Number, | | | | | | one |
| i | 4 Mornicide detarmined building, atc. (Specify) Assistance City or Town, State) S. (The North Hamping) | | | | | | | | | | 2"3 |
| COMPLETIES | 29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYS | | | | | | | | | o(s) and manner as | stated. |
| | 29b, SIGNATURE AND TITLE OF CENTIFIC | 6.8 | // | | | 29c. LICENSE NU | | | | D (Month, Day, Year) | |
| 7 | SEN GIGHTATURE AND RELEASE CERTIFIC | MI | · C | | | O.C.M | | | ST 19,1 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUS | | | | et, Bal | timor | e, Mar | ylan | d 21201 | L |
| | 31. DATE FILED (1977) 23 1995 | A PEGISTRA | IR'S SIGNATURE | | | | | | | | |
| | 1 1333 | Amen's | A Indian | 74.A | | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | FOR | |
|---|---|-----------|--|
| 1 | _ | STATE | |
| ı | | DEGISTRAD | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

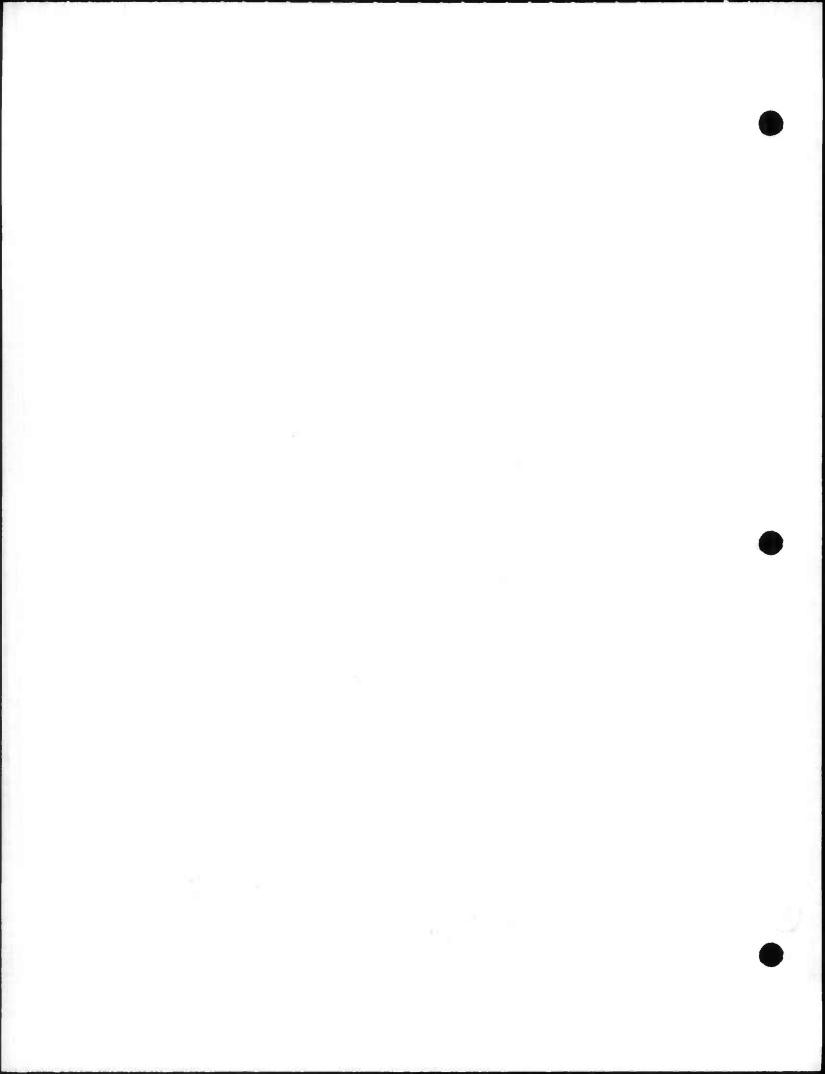
| | REGISTRAR | | CE | RTIFIC | CATE OF | DEATH | R | EG. NO. | | | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------|-------------------|------------------------------|-------------------------------------------------------------|-------------------------------------|--------------------------|-----------|----------|------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last |) | | | | | 2. DATE OF C | DAY | | YEAR | 3. TIME OF OEATH |
| | JOSE | | | RAM | IREZ | | AUGU | ST 1 | 9,19 | 95 | 0139 Am |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. lest | | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF B (Month, De MAY 2 | HRTH Y. Year) 5 19 | 62 | Country) | LACE (State or Foreign DURAS |
| | UNAVAILABLE 9a. FACILITY NAME (if not institution, give | street and number) | | 1 | | OR LOCATION OF O | EATH | | 9c. COUN | TY OF DE | |
| 9 B | 916 NORTH HAMI | PTON DRIVE | | | SILVE | K SPKIN | G | | MOI | 1160 | MEKI |
| | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | TY | | 10c. CITY, | TOWN OR LOCA | ITION | | | | | 10d. INSIDE CITY |
| DIRECTOR | 1 100110 | GOMERY | | SILV | ER SPR | | | | | | LIMITS? |
| FUNERAL | 10e. STREET AND NUMBER 916 NORTH HAMPTO | ON DRIVE | | | 1 | 20903 | | | | DURAS | AAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 | YES 2 XN | MED D | If yes, s | CENDENT OF HISPAI pecify Cuban, Mexica S 2 NO Specifi | in, Puerto Ricar | | or No— | | - American Indien, White, etc. PANIC |
| | 15, DECEDENT'S EG (Specify only highest gra | DUCATION de completed | | | SUAL OCCUPAT | | 16b. KIN | OF BUSI | NESS/INDL | USTRY | |
| Ш | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | Do NOT use | retired.) | lost of working | | | | 11 | |
| COMPLETED | 6TH | | COI | NSTRU | CTION | | | XI CC | | Y | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | | le, Maiden S | lumame) | | |
| 8 | JOSE DE-LA RO | SA MOYA | T | | | TOMAS R | | | 20111-200 | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | (TD 77 | - 1 | | | and Number or Rural IPTON DR. | | | | | 0003 |
| | RARIO JAVIER RA | MIREZ | | | DISPOSITION (| | DATE | | ATION — C | | |
| | 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) | moval from State | FAMILY | natory or othe | er placel | | 28/95 | | PEDR | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | CENSEE | | | 22. NAME | BACON FU | CILITY NEDAT | HOME | TNC | | |
| | v.1/ | Baca | 27 | 76 | | 14TH STR | | | | | 20010 |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | C | | QUENCE OF) | | hot h | ound | 8 | | | Onset and Death |
| CERTI | thet initiated events resulting in death) LAST | d | | | | | | | | | |
| PHYSICIAN: MEDICAL | | | | | | | | | | | WERE AUTOPSY FINGINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AA | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLAC | | (Check only on |) | | | | | |
| SIC | EXAMINER? XXYES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify) | | | | | | | | | | |
| | 27. MANNER OF OEATH 1 Natural 5 Pending | 28a. DATE OF INJ (Month, Day, 1 | URY -GS | 28b. TIME INJU | RY | YES 2 VINO | Sus | BE HOW IN | JURY OCC | Shot | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined 286. LOCATION (Street and Number or Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Number of Bural Figure Numb | | | | | | | | | | un onve |
| COMPLETED | CONCR UNITY | YSICIAN: To the best of my INER: On the beels of exam | - / | | | | | | | | and menner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTA | Gr G | 4 | | | O.C.M. | | | | | (Month, Day, Year) (19,1995 |
| | Dowid R | Earler | 111 | Penn | | et, Balt | imore | e, Ma | aryl | and | 21201 |
| | AUG 23 1995 | 32. REGISTRAR'S | SIGNATURE | all | | | | | | | |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

| | | HEGISTRAN | | | CERTIF | TCATE | UF | DEA | <u> </u> | R | EG. NO. | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------|------------------------------|------------------------------------------------------------------------------------------------|--------------------|--------------|-------------|----------------------------|------------|-----------------|--------------|--------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DEATN | Y 1.0 | YEAR | 3. TIME OF DEATH |
| | | Fern J. Radich | 5. SEX | A AGE (In | yrs. lest birthday) | IF UNDER | . WEAR | Laura | | Augus | | , 19 | 95 | 8:23 P w |
| | | 205-12-1580 | 1 🗆 M 2 🗔 F | 88 | | MONTHS | DAYS | HOURS | MIN. | 7. DATE OF E (Month, Da | y, Year) | | a. BIFTHI | PLACE (State or Foreign |
| should | | 9a. FACILITY NAME (If not institution, give s | 4141 | | | 9b. CITY, | TOWN (| OR LOCATION | ON OF DE | May 2 | 4. | 907 sc. cour | Pent | nsylvania EATN |
| 2, 3 s | e e | Larkin Chase Nur | sing Cen | ter | | Boy | 7ie | | | | | Pri | ice (| George's |
| - - | 녆 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | , | | 100 00 | TY, TOWN O | 0.1.0041 | ZION. | | | | | | |
| Pages | DIRECTOR | | e George | t _e | 7. | wie | LOUA | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| permit. | 1 1 | 10e. STREET AND NUMBER | - 000180 | | 1 100 | WIE | 101 | . ZIP CODI | E | | | 10g. CITE | | 1 XYES 2 NO |
| 每 | ERAL | 13902 Pleasant | View Dr | ive | | | | 2072 | 0 | | | | | States |
| DZU physician. burial-transit | FUN | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDEN | | | 13. V | AS DEC | ENDENT O | F NISPAN | IIC ORIGIN? (S | pecify Yes | | 14. RACE | - American Indian, White, etc. |
| 5-UUZU nding physic is the burial | B≺ | 3 🖾 Widowed 4 🗌 Divorced | IF YES, GIVE V | | | | | 2 X NO | Specify | | , 610.) | | Specifi | |
| IND X1X15-UUXU hospital or attending physician, ached for use as the burial-tran ce. | 8 | 15. DECEDENT'S EDU | CATION | | 16a. DECEDENT | USUAL OC | CUPATIO | ON . | _ | 16b. KIN | D OF BUS | INESS/IND | | .ce |
| al or al for us | 1 1 1 | (Specify only highest grade Elementary/Secondary (0-12) 8 th | (Give kind of life. Do NOT (| work done di se retired.) | uring mo | st of workin | g | -11-20-000 | | | | | | |
| he hospit detached | COMPL | | | | Hom | emake | r | | | Ow | n Hor | ne | | |
| e de la | | 17. FATHER'S NAME (First, Middle, Lest) Frank Crans | | | | | | 1000 | | ME (First, Middle | | Sumame) | | |
| retained by S should b | BE | 19e. INFORMANT'S NAME (Type/Print) | | | 195 MAH IN | Anness | (Stead o | | | Delci | | Chata Tia | 0-4-1 | |
| or retained 5 should notified | 임 | Dixie Nemeth | | | | | | | | rive, | | | | 20 |
| may be | | 20e. METHOD OF DISPOSITION 1 D Buriel 2 Cremetion 3 1 Remo | numl form State | 20b. | PLACE AND DATE | OF DISPOSE | TION /Na | me of | | DATE | | ATION — | | |
| Page 6 ma al director, p | | 4 Donation 5 Other (Specify) | | Sy. | tery, cremetory or Ivania | | | | | 8/25 | Beav | er C | ount | y, PA |
| death. Pag funeral di examiner | | Sylvania Hills Memorial 8/25 Beaver County, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. | | | | | | | | | | | | |
| after death. y the funer. moval. ical exami | | Robert E.C | Vans | Mes | | 16 | 000 | Anna | poli | is Road | d. Bo | wie. | MD | |
| | | 23. PART I. Enter the diseases, or ehock, or heart failure. | complications the List only one cau | it caused use on eac | the death. Do ch ilne. | not enter t | the mo | de of dyi | ng, auch | aa cardlec | or reapir | atory arm | eat, | Approximate interval Between Onset and Death |
| or or net of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of t | | disease or condition resulting in death) | Co | nge | ch'n | Q t | tec | 190) | -1- | wile | 00 | | | SUS. |
| ompleteh d, cremar event, | | | DUE TO | (Of ASA | CONSEQUENCE | F): | 1.(- | 1 | _ | | | | | 1303 |
| and and | ON | Sequentially liet conditions, | DUE TO | (OR AS A | CONSEQUENCE | 1 | a | Sel | 7 | 10 | KO | rfc | - 1 | 7543 |
| Sician prior I | CATION | If any, leading to immediate cause. Enter UNDERLYING | | (0), 10, 11 | onocoocino. | ,,. 0 | | | | | | | | |
| | RTIFI | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| E E E | ши | resulting in death) LAST | | | | | | | | | | | | |
| 2 8 8 5 | IL C | PART ii. Other algnificent condition | e contributing to | death bu | t pot reeuiting | In the ung | priying | ceuse g | iven in i | Part i. 24a | . WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| any the that | EDICAL | chron's o | noth | LIC | tino | Pul | m | gro | UAI | Differ | YES 2 | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | W VES 2 PHO | | | | | | | | | | | 1 TYES 2 NO | | |
| The law require has been ate Dept. of em 23 sho | | DID TOBACCO USE CONTI | RIBUTE TO CA | | | | | UNC | ERTAIN | <u>/</u> | | | | |
| PHYSICIAN: The law requires certificate has been with the State Dept. of riced, or Item 23 sho | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | | ACE OF DEATH (Check only one) OTHER: 3 □ DOA Warring Nome 5 □ Residence 6 □ Other (Specify) | | | | | | | | |
| PHYSICIAN: this certifica with the Starked, or Its | | 27. MANNER OF DEATH | 1 Inpatient 2 28e. DATE OF | INJURY | tient 3 L DOA | | ng Nom 28c, INJ | | sidence | 6 Other (Sp. 28d. DESCRIE | | THBY OCC | HOED | |
| | ВУ Р | 1 Natural 5 Pending | (Month, D | Ney, Year) | IN | JURY M | WO | RK7 (ES 2 | NO | | | | oneo | 100 |
| J S S S | | 2 Accident 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office 28st. LOCATION (Street and Number or Rural Route Number, | | | | | | | | | | | oute Number, | |
| OR ATTEN DIRECTOR: hours after Item 28 | ETE | 4 Homicide determined | | | | | | | | | ,, | | | |
| AL DIRECTOR AL DIRECTOR MINISTRACTOR MINISTR | COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 NO IMPORTANT; If IN | Ö | | | xamination | end/or investigati | on, in my op | inion, d | eath occur | ed at the t | time, data end | place, end | due to the | cause(s) | and manner as stated. |
| THE F | BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 1-5 | 1 0 | 1/11 | 11/ | | 29c, LICE | NSE NUM | BER _ | 7// | 29d. DATE | SIGNED (| (Month, Day, Year) |
| ₽ £ 8 9 9 | 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (LFEM 27) (Type, Print) | | | | | | | | | | | | |
|) | | Sam Tellawi, M.D | | | ellvill | | d. | Bow | ie. | MD 207 | 16 | | | |
| | | 31. DATE FILED (Month, Day, Year) AUG 25 1995 | | | Mardall | | , | | , | 201 | | _ | | |
| | | MUG 25 1995 | Juna | -0.000 | - PURCULA | | | | | | | | | |





BALTIMORE, MARYLAND 21215-0020

permit, Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| M SET | F F # 8 | # # # E | 오픈물론 | 5 9 4 5 | 祖礼だ言 | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | IN THE FUNDAM, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit | e med within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

27. MANNER OF DEATH

1 Natural 2 Accident
3 Suicide

4 Homicide

31. DATE FILED (Month, Day, Year)
AUG 21 1995

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| | t. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | 2. DATE O | F DEATH | AY | YEAR | 3. TIME OF DEA | TH |
| | LOUIS | WARRI | EN | REE | D | | | | | | AUGU | | . 19 | | 2.45P | M |
| | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In | GE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTY (Month, Day, N | | | | | | | | 8. BIRTI | HPLACE (State or F | preign | |
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| E | Maryland | | | 1 - | | | | | ION | | | | | | 10d. INSIDE CITY LIMITS? | |
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| | 1 Never Married 2 1 | Married | 12. WAS DECEDEN FORCES? 1 | X YES | 2 NO | HED) | | it yes, sp | ecify Cubar | ı, Mexica | IIC ORIGIN? n, Puerto Ric | (Specify Yes | or No- | 14. RACI Black | E — American Indi k, White, etc. | en, |
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| ۳ | Elementary/Secondary (0- | -12) | College (1-4 or 5 | +) | | | se retired.) | | | | | | | | | |
| \$ | 12 17. FATHER'S NAME (First, Min | | _ | | Mai | nter | nance | Woi | | | | | | lic S | Schools | |
| | | | 1 | | | | | | | | ME (First, Mi | | Sumame) | | | |
| BE | George Warren Reed Ellen Rudden 198. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | | | | |
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| | t X Buriel 2 ☐ Cremation 3 ☐ Removal from State Cor | | | | | atory or o | of DISPOS | | | | DATE | | CATION — | City or To | own, State | |
| 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 8/17/95 Brentwood 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | d, M | iaryland | | | | | | | |
| 1 | 21. SIGNATORE OF PUNERAL | SENAICE LIC | ENSEE | - | | _ | Fo. | name ar rt T | ID ADDRES | of fac | unera | 1 Нот | ne. T | nc. | | |
| | 1/20 | un | _ / . | / | | 3401 Bladensburg Rd., Brentwood, MD 2072 | | | | | | | 22 | | | |
| | 23. PART I. Enter the dis shock, or he | seases, or coart fallure. I | omplications the | t ceused i | the dead | th Do | act enter | tha mo | de of dyle | ng, suct | h aa cardla | c or reap | ratory ar | reat, | Approxim | ate |
| Ì | immediate cause (Final disease or condition as Shot gum wound lest face with any theatims | | | | | | | | | | | | Onset and | | | |
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| 5 | CAUSE (Disease or injur | | Dise wa | (OR AS A C | ONESO | ENGS C | D. | | | | | | | | | |
| ERTIFICATION | that initiated events resulting in death) LAST | r | 00E 10 | O A CA NO | ONSEOU | ENCE O | r): | | | | | | | | | |
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☑ NO □

PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

1 TES 2 NO UNCERTAIN

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 | YES 2 | NO

25. WAS CASE REFERRED TO MEDICAL EXAMINERT

1 VES 2 NO 26. PLACE OF DEATH (Check only one)

HOSPITAL: OTHER:
4 | Nursing Home 3 DOA 280. DATE OF INJURY (Month, Day, Year) 7 - 24 - 95 286. TIME OF INJURY

5 🗌 Residence 6 Other (Specify) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED

24s. WAS AN AUTOPSY PERFORMED?

1 CERPIFYING PHYSICIAN: To the best of my kno 2 MEDICAL EXAMINER: On the besis

29s. CERTIFIER (Check only one)

6 Could not be

29d. DATE SIGNED (Month, Day, Year)

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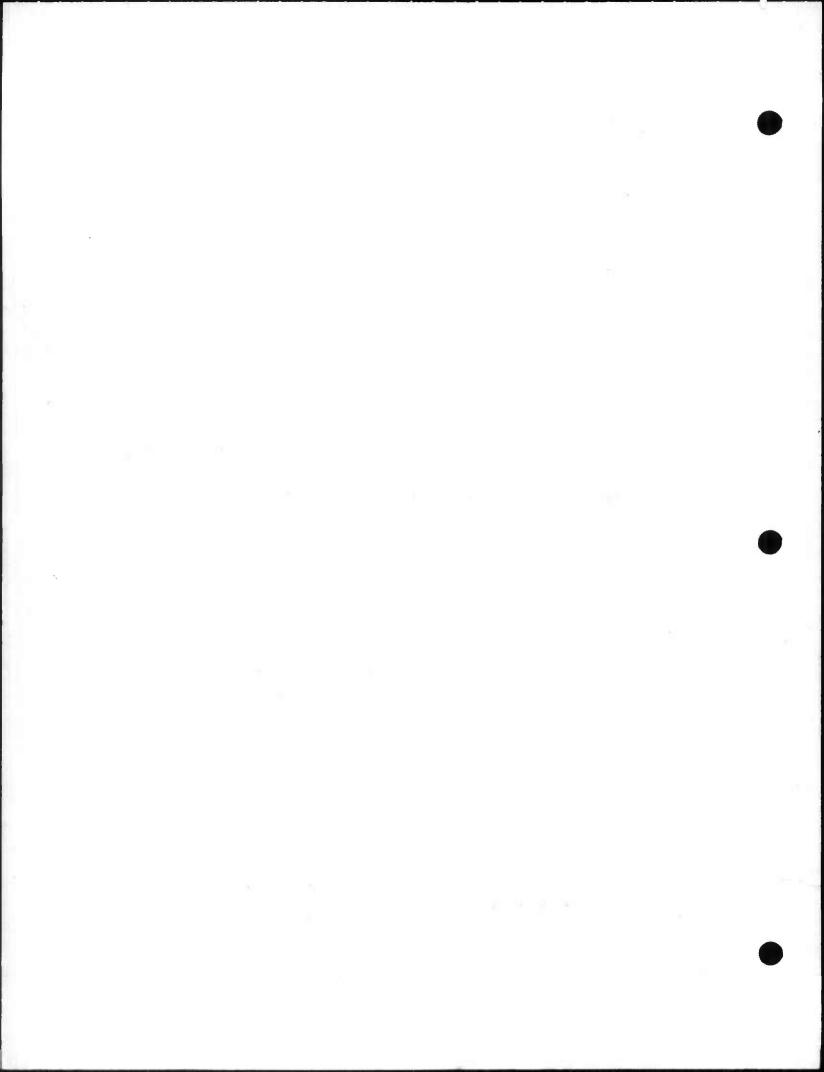
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | RA | REC |
| | 0 7 | 0 |
| | PITA | ERA |
| | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be re | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 |
| | 부 | 부 |
| | - | - |

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|-------------|-------------------------------------------------------------------|----------------------------|
| idle, Last) | | 2. DATE OF DEATH |

| | | 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEI CERT | PARTMENT | OF HEA | ALTH AND I | MENTAL HYGIEN | | |
|---------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------|------------------------|--------------|------------------|-------------------------------------------------|---------------|--------------------------------------------------|
| | 8 | 1. DECEDENT'S NAME (First, Middle, Las | 1) | | | | | 2. DATE OF DEATH | DAY 1 | 3. TIME OF DEATH |
| | | GRANT | | RAY | JR. | | | AUGUST 15 | 5. 199 | 1 000 |
| | | 4. SOCIAL SECURITY NUMBER | | NE (In yrs. last birth | MONTHS | | UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | . BIRTHPLACE (State or Foreign Country) |
| pin | | 577-54-2816 | 1X M 2 🗆 F 5 | 4 YF | 3. | | 1100 | Sept. 4, 19 | 40 W | ashington D. |
| 3 should | Œ | 9s. FACILITY NAME (If not institution, give | | | 9b. CITY, | TOWN OR L | OCATION OF DE | ATN | 9c. COUNT | Y OF DEATN |
| 1, 2, | DIRECTOR | Prince George | <u>'s Hospita</u> | 1 | C | heve | rly | | Prin | ce George's |
| sade | REC | 10a, STATE 10b, COUP | ITY | 10c. | CITY, TOWN OF | R LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| Jif. P | | | nce George | 's L | andove | er | | | | 1 XYES 2 NO |
| physician. burial-transit permit. Pages | FUNERAL | 10e. STREET AND NUMBER | 01 | | | | CODE | | | N OF WHAT COUNTRY? |
| rans-trans | N. | 702 Carlough | 12. WAS DECEDENT EVER | 2 10 11 0 40000 | | | 785 | | U.S | |
| physician. burial-tran | | 1 Never Married 2 Married | FORCES? 1 X YE | S 2 NO | lf. | yes, specify | y Cuben, Mexical | IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | a or No 14 | I. RACE — American Indian, Black, White, atc. |
| g a | ВУ | 3 Wildowed 4 Divorced | June 60- | | | YES 2 | X NO Specify | | | Specify: Black |
| | 윤 | 15. DECEDENT'S Et (Specify only highest gra | DUCATION | 16a, DECEDER | IT'S USUAL OCC | CUPATION | f working | 16b. KIND OF BU | SINESS/INDUS | |
| 4 m 5 | " | Elementary/Secondary (0-12) | College (1-4 or 5+) | TRAIN | TVIROE A | UTOMA | TIC | | | |
| the hospital detached it once. | COMPLET | 12th 17. FATHER'S NAME (First, Middle, Last) | 2yrs | Tech | niciar | | | | | t(w/ METRO) |
| by the hospit be detached at once. | EC | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | - 1 | | ME (First, Middle, Meiden | , | |
| retained 5 should notified | 0 | Grant Ray, S | | 19b, MAII | ING ADORESS | | | CMillian Fouts Number, City or Tow | | ndal |
| 5 5 | 2 | Patricia Ray | / WIFE | 70 | | | | Landover | | |
| 2 2 | | 20e. METHOD OF DISPOSITION 1 Description 2 Cremation 3 Re | 2 | 0b. PLACE AND DA | TE OF DISPOSIT | TION (Name o | of | OATE 20c. LO | CATION — CIT | y or Town, State |
| a ect e | | 4 Donation 5 Other (Specify) | | emetery, cremetory Harmon | or other place) y Memo | orial | l Park | 19,1995 I | ando | ver,Md |
| | | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | 1. 211 | 22. N | AME AND A | DDRESS OF FAC | | | |
| | | - Jugwa | Un. L | NULITY | | | | | | er,Md 20785 |
| ie de a | | 23. PART I. Enter the diseases, o | r complications that cause. List only one cause on | ed the death. I | o not enter t | he mode | of dying, such | as cardiac or reap | iratory arres | t, Approximate |
| | 1 1 | IMMEDIATE CAUSE (Final | . List only one cause on | A. | 1 | Pa | _ | 21 | | Onset and Desth |
| | | disease or condition resulting in death) | · Muli | isys | lem | 1 | Fart | line | | 3week |
| D 0 7 | | 0.000 | DUE TO (OF AS | A CONNEGUENO | E OF): | | | | | 3 |
| and o bur | ON N | Sequentielly list conditions, | DUE TO JOH AS | A CONSEQUENC | E OFI: | | | | | Swall |
| | SAT | if any, leading to immediate cause. Enter UNDERLYING | . less | 2m | 123 | / | 7 | | | 13400 |
| | Ē | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENO | # OF): | 11 | | | | J- EEG |
| H. H. | CERTIFICATION | resulting in death) LAST | a 6-1 | se | eeg | - | | | | weel |
| E de c | AL C | PART II. Other significant condition | one contributing to death | but not resulti | ng in the und | erlying ca | use given in I | Part i, 24e, WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| | 2 | | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Sign Sign | 말 | | | | | | _ | 1 TES 2 | : _ NO | OF DEATH? |
| 204 | z | DID TOBACCO USE CON | TRIBUTE TO CAUSE | OF DEATH | YES N | 0/1 | UNCERTAIN | <u></u> | | |
| | PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF I | OTHER: | | | | | |
| SICIAN: The Certificate to the State | IXS | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Ou | | A 4 🗆 Nursir | ng Homs 5 | | 6 Other (Specify) | | |
| NG PHYSI fter this c eath with marked, | | 1 Natural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | | TIME OF 2 | WORK? | | 28d. OEŞCRIBE HOW II | NJURY OCCUP | RED |
| WDING H | ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 26a PLACE OF IN HE | RY — At home, far | m street factor | | 2 NO | 28f. LOCATION (Street s | and Mumber on | Count Day to North as |
| TTEN TOR: after | | 4 Homicide 6 Could not be determined | building, atc. (Sp | Decify) | | ,, | | City or Town, State) | no number of | nural House Number, |
| DIRECT PORT | 1 1 | 29s. CERTIFIER 1 CERTIFYING PHY | SICIAN: To the best of my kno | wiedos daeth oc | turned at the tim | no dete and | place and due l | to the equation and man | | |
| HOSPITAL FUNERAL WITHIN 72 TANT: IT | COMPLETED | | | | | | | | | ause(s) and manner as stated, |
| E FUNEF d within | Ш | 296. SIGNATURE AND TITLE OF CERTIFI | | | | | LICENSE NUM | | | IGNED Movim, Day, 1965 |
| TO THE HOSPI TO THE FUNER De filed within IMPORTANT: | m | 1/00 | even | _ ' ~ | 0 | / | 2303 | 18 | P 8 | 11/05 |
| 5 | 2 | 30. NAME AND ADDRESS OF PERSON W | MO COMPLETED CAUSE OF | EATH (TEN 3 | ype, Print) | / | 21. | 1 1 5 | 7 | 10/73 |
| (4) | | P.G. Hospital | BOOT HOS | Pital | DRIV | e (| neve | erly M. | D 2 | 5784 |
| | | AUG 21 1995 | alia de l'Eschibar Pais | WALLE . | | | | | 17.0 | |
| | - 0 | 0 | | | | | | | | |



|) | physician. | burial-transit |
|---|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| | attending | se as the |
| | be executed within 114 hours after death. Page 6 may be retained by the hospital or attending physician | ian and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit |
| | etained by t | should be |
| | ge 6 may be | irector, page |
| | after death. Pa | y the funeral of |
| | Sunou 52 | / filled in b |
| | ecuted within | nd completely |
| | De ex | ian a |

69 ETED.

CERTIFICATION

PHYSICIAN: MEDICAL

ΒY

COMPL

1 YES 2 NO

Pages 1, 2, 3 should

permit.

BALTIMORE. MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| t: The law requirecate has been s | ICIAN | A ATTENDING PHYSICIAN | TO THE MISSITIAL OR ATTENDING PHYSICIAN THE FUNERAL DIRECTOR: After this certification within 72 hours after death with the 9 MPORTANT: If Item 28 is marked, or |
|-----------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| State Dept. of Hitem 23 show | the the | RECTOR: After this certificate death with the 8 is marked, or | |
| | ICIAN: The law requir certificate has been si the State Dept, of He or item 23 show | R ATTENDING PHYSICIAN: The law requir RECTOR: After this certificate has been si urs after death with the State Dept. of He im 28 is marked, or item 23 show | TO THE MISHINGLOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing Notice that have 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the page of the state of the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. INPORTANT If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

95 27175 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Leet) 2. DATE OF DEATH 3. TIME OF DEATN Margaret Rilev Ann August 14. 1995 2:10 P 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8/18/44 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 M 2 X F 50 YRS. 578-60-0980 Washington, D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN 1105 Broadview Rd. DIRECTOR Ft. Washington Prince George RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George Ft. Washington t X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WNAT COUNTRY? 1105 Broadview Rd. 20744 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicon, Puerto Rican, etc.)
 U YES 2 Y NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 12th <u>Congressional Aide</u> Federal Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) James J. McGinnis BE Mary C. Ghelmini 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 David P. Riley same as item 10 20e. METNOD OF DISPOSITION
1 X Burisl 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Cedar Hill Cemetery Donation 5 Other (Specify) 8/17/95 Suitland, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home Heo 6160 Oxon Hill Rd. Oxon Hill, Md.20745

23. PART I. Enter the seeses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a neart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onest and Death disesse or condition resulting in death) Cancer of the Colon with Metastices Months DUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1 - YES 2 X NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖫 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL

27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netural м 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Nomicide

26. PLACE OF DEATN (Check only one)

OTHER:

29e. CERTIFIER
(Check only one)
2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify)

D-18545

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

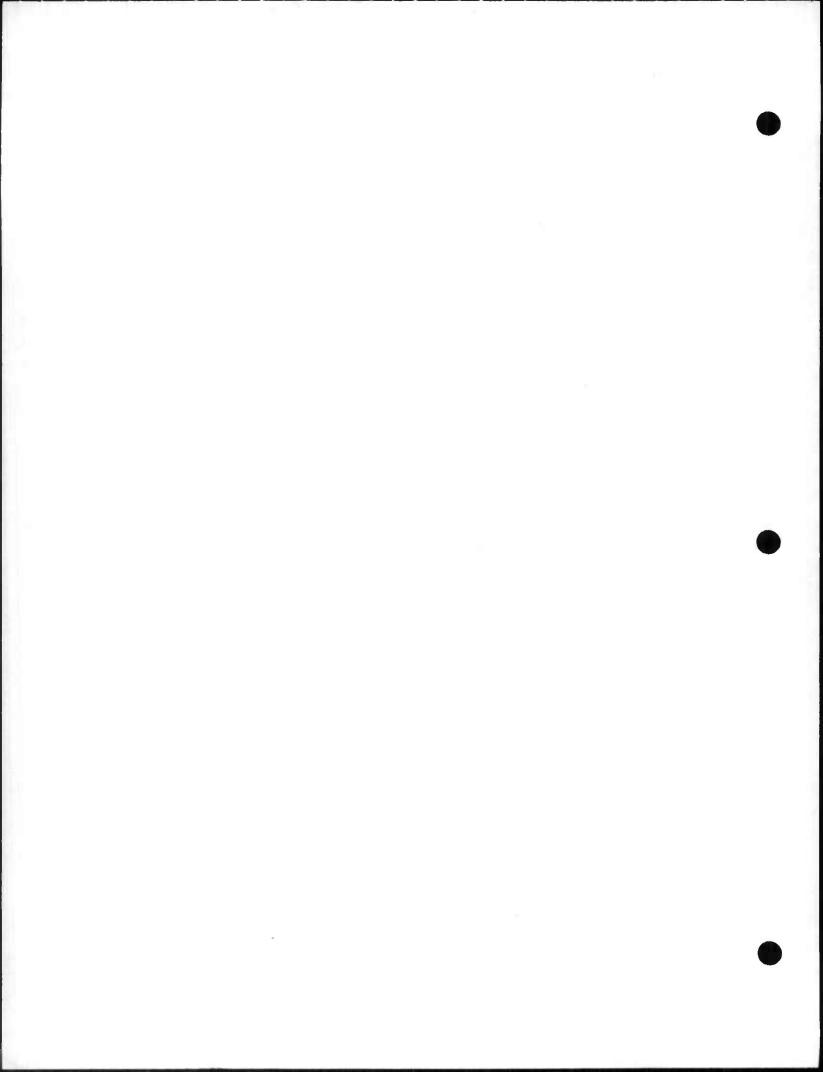
Philip Witsotsky, M.D. 6188 Oxon Hill Rd. Oxon Hill, Md.20745

31. DATE FILED (Month, Day, Year)

HOSPITAL:
1 | Inpatient 2 | ER/Outpetient 3 | DOA

32. REGISTRAR'S SIGNATURE in Stucken hardall 1995 AUG 21

August 14,1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 The Hospital or retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

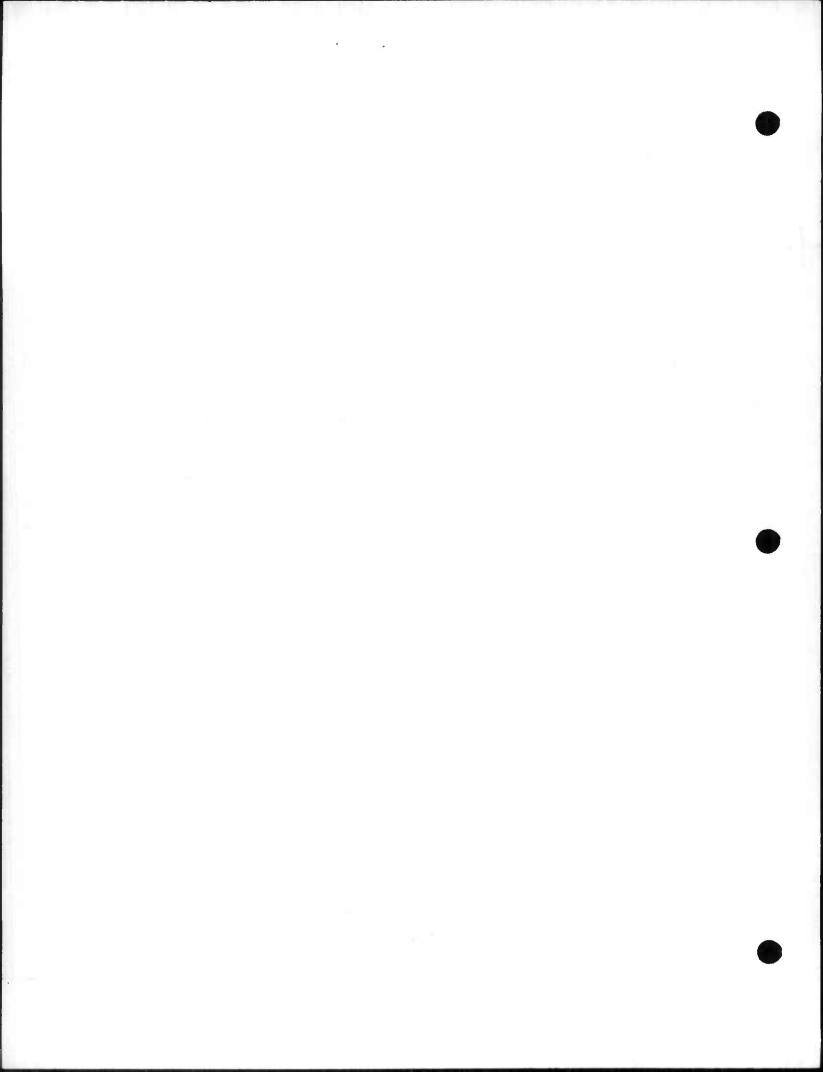
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | TEGIOTTAN | | C | -1111111 | CATE | - DEAI | | REG. NO. | | | |
|---------------|-----------------------------------------------------------|-----------------------------------------|----------------------------------------|------------------------------|--------------------------------|-----------------|------------|--------------------------------------------------|------------|--------------|----------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH MONTH DA | v | YEAR 3 | 3. TIME OF DEATH |
| | ROBERT | В. | | | ROSS, | SR. | | July 3 | 0 1 | 995 | 4:40 a m |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX (| AGE (In yrs. les | | IF UNDER 1 YEAR | | 24 HRS. | 7. DATE OF BIRTH | | A BURTUR | ACE COLLEGE STATE |
| | 215-44-6367 | 1 XM 2 - F | 86 | YRS. | MONTHS DAYS | HOURS | MIN. | SEPT. 19, 1 | 908 | MAR | YLAND |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, TOW | OR LOCATIO | | | | ITY OF DEA | |
| E | MEMORIAL HOS | TATTOS | | | | STON | | | | CALBO | |
| DIRECTOR | RESIDENCE OF DECEDENT |)T T I VII | | | Liate | DION | | | | LALID | 01 |
| Ä | 10a. STATE 10b. COUNTY | | | 10c. CITY | TOWN OR LOC | ATION | | | | T | IOd. INSIDE CITY |
| <u>a</u> | MARYLAND TALE | ВОТ | | I | EASTON | | | | | Ι, | LIMITS? |
| 4 | 10s. STREET AND NUMBER | | | | | IOF. ZIP CODE | | | 10a, CITI | _ | AT COUNTRY? |
| FUNERAL | 303 LINDEN AVE | THE | | | | 216 | 501 | | | USA | |
| Z | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. AR | MED | 13 WAS D | | | IIC ORIGIN? (Specify Yea | as No. | | - American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 [| YES 2 1 | 10 | I1 yes, | specify Cuban | , Mexicer | n, Puarlo Rican, etc.) | OF IND | Black, 1 | White, etc. |
| ВУ | 2 Widowed 4 Divorced | 11 1 CO, GIVE 104 | OR DATES | | 1 1 1 | S 2 XNO | Specify | r. | - 1 | Specify: | WHITE |
| COMPLETED | 15. DECEDENT'S EDUC | ATION | 16a, DE | CEDENT'S L | SUAL OCCUPA | TION | | 16b. KIND OF BUS | INESS/IND | USTRY | |
| | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | (G life | ive kind of wi Do NOT use | ork done during i retired.) | nost of working | 7 | 311121111111111111111111111111111111111 | | | |
| 7 | 12 | 1 | ASS | ביתי ד | POSTMA | STER | | U.S. P | ОСТ | AT. SI | FRVTCE |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | ADI | , 1 1 | ODIM | | ED'S MAI | ME (First, Middle, Maiden 3 | | и от | ERVICE |
| U C | EMORY A. ROSS | | | | | III. MOTH | | ALICE RYA | , | | |
| 00 | 19a. INFORMANT'S NAME (Type/Print) | | 400 | MARINO. | 200500 (0) | | | Toute Number, City or Town | | | |
| 임 | MARGARET R. WI | CF | | | | | | EASTON, | | | 0.1 |
| | 20a, METHOD OF DISPOSITION | LDE | | | | | NUE | | | | |
| | Nation 2 Cremation 3 Remo | wat from State | | | DISPOSITION | | ות גם | 1 | | City or Town | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | IMOODI | LAWN | | | _ | | STO | N, MI | <u> </u> |
| | L. SIGNATORE OF FOREIGN SERVICE ECO | ENGEE | | | NEWN | AND AODRES | INF. | RAL HOME, | P.A. | | |
| | JOHN R. | MERCER | 22 | FCP | 200 | S. HZ | ARRI | ISON ST. | EAS | KOTE | MD |
| | 23. PARI I. Enter the diseases, or co | omplications that | eused the de | ath. Do no | t enter the m | ode of dyin | ng, such | aa cardiac or reapir | atory arm | est. | Approximate |
| | snock, or heart failure. L | lst only one cause | on each line | | | | | | | | Interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | BANK | - I mno | . 0 | 2748 | 00- | c 774 | 21 | | | Onset and Death |
| | resulting in death) | DUE TO (C | R AS A CONSE | DITENCE OF | . 116 | 1100 | 2/1/ | 7C | | | 14425 |
| - 1 | _ | Dine | 1 Eail | c. all | • | | | | | | |
| CERTIFICATION | Sequentially list conditions, | RINA | R AS A CONSEC | DUENCE OF | | 4 | | | | | - |
| ¥ | if any, leading to immediate cause. Enter UNDERLYING | CONS! | erive | han | 7 8 | 2/100 | 1 | | | | i 1 |
| 프 | CAUSE (Disease or Injury that Initiated events | DUE TO (O | R AS A CONSEC | DUENCE OF | : | TUR | | | | | - |
| E | reaulting in death) LAST | | | | | | | | | | |
| 빙 | | • — — — — — — — — — — — — — — — — — — — | | | | | | | | | |
| EDICAL | PART ii. Other algnificant conditions | contributing to d | eeth but not r | esuiting in | the underlyl | ng ceuse gi | iven in i | Part I. 24a. WAS AN A | | | ERE AUTOPSY FINDINGS |
| 응 | | | | | | | | 1 TES 2 | | C | OMPLETION OF CAUSE |
| | | | | | | | | | | | F DEATH? |
| 2 2 | DID TOBACCO USE CONTR | IBUTE TO CAU | SE OF DEA | TH YES | Пиол | 7 UNCE | RTAIN | | | | |
| ₹ | 25. WAS CASE REFERRED JO MEDICAL | | | | (Check only on | | | | | | |
| S | EXAMINER? | HOSPITAL: | B/Outpetlant 2 | | OTHER: | | 75.90 N | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF IN | | 28b. TIME | | IJURY AT | idenca (| 8 Other (Specify) 28d. DESCRIBE NOW IN | #15W 000 | 11050 | |
| | 1 Naturel 5 Pending | (Month, Day, | | เทาก | RY W | ORK? | | 200. DESCRIBE NOW IN | JUHY OCC | UHED | |
| BY | 2 Accident Investigation | 28e. PLACE OF | N II I I I I I I I I I I I I I I I I I | | | YES 2 | NO | | | | |
| COMPLETED | 3 Suicide 6 Could not be 4 Homicide determined | building, et | c. (Specify) | nrw, rairin, ani | eet, inctory, on | ica | | 261. LOCATION (Street ar City or Town, State) | nd Number | or Rural Rou | ite Number, |
| ᄪ | | | | _ | | | | | | | |
| 릴 | (Check only one) | | | | | | | | | | |
| ō | 2 MEDICAL EXAMINER | t: On the basis of exar | nination end/or i | nvestigation | In my opinion, | death occure | d at the t | time, data and placa, and | due to the | ceuse(s) a | nd manner as stated, |
| m II | 296. SIGNATURE AND TITLE OF CERTIFIER | 1/1/ | | | | 29c, LICEN | ISE NUM | BER | 29d. DATE | SIGNED (M | Ionth, Day, Year) |
| 00 | 2 mly // Cs | lution | non | | | Di | 3/4 | 166 | 1 5 | 7/30 | 195 |
| 임 | 30. NAME AND ADORESS OF PERSON WHO | COMPLETEO CAUSE | OF DEATH (ITEN | 1 27) (Type, F | Print) | 11/ | // | 00 | | 1 | 13 |
| Į III | | | | | | | | I C T T T T T | | | |
| | LUDWIG J. ECT.S | SEDER T | II. M. | D | 606 T | UTCH | MAN | S LANE | EAS | I'ON - | MD I |
| | LUDWIG J. EGLS 31. DATE FILED (Month, Day, Year) | SEDER, I | II, M. | .D., | 606 D | UTCH | MAN | S LANE, | EAS' | ron, | MD |
| | | 32. DEGISTRAR | II, M. s signature | D., | 606 D | UTCH | MAN | S LANE, | EAS' | ron, | MD |



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

0)

Georgia

Aus.

Pages 1, 2, 3 should

permit.

as the burial-transit

use

for

detached

should be

firector, page 5

BALTIMORE, MARYLAND 21203-3146

| uneral | | camine |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| by the | moval. | ical e |
| lled in | n, or re | e med |
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| TOR: AI | after de | 28 Is |
| DIREC | hours | Item |
| UNERAL | ithin 72 | NAT: II |
| THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral of | he filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 Is marked, or item 23 shows any injury, or other traumatic event, the medical examine |
| × | _25 | |

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last). 2. DATE OF DEATH 3. TIME OF DEATH 1995 9:15 follins August 11 110 A A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 1X M 2 - F DAYS HOURS VDC Georgia 252-26-3662 9a. FACILITY NAME (If not institution, give street and number) 90 COUNTY OF DEATH 95 CITY TOWN OR LOCATION OF DEATH DIRECTOR Manor Care Nursing Home Silver Spring Montgomery County RESIDENCE OF DECEDEN 10d. INSIDE CITY 10c. CITY, TOWN OR LOCATION 10b. COUNTY Washington, D.C. 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10a STREET AND NUMBER 101, ZIP CODE andelph J Place N.W. 30 Randall Place, 20001 United States 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-ORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 Never Married 2 Married BΥ 3 Widowed 4 Divorced **Black** 0 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 15. DECEDENT'S EDUCATION (Specify only highest grade comple COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 6 Reverend Ministry 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Flournoy Williams Rollins BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Magdalene Rollins 30 Randall Place, N.W., Washington, D.C. 20001 METHOD OF DISPOSITION
Burial 2 Cremation 3 Re 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c, LOCATION — City or Town, State Fort Lincoln Cemetery 8/21/95 Brentwood, Maryland 22. NAME AND ADDRESS OF FACILITY 21, SIGNATURE OF FUNERAL SERVICE LICENSEE Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd. . B rentwood MD 20722 23. PART I. Enter the diseases, or complications that caused the de whiler the mode of dying, such as cerdiec or respiratory arrest. **Approximate** interval Between shock, or heart failure. List only one cause on as Onset and Death IMMEDIATE CAUSE (Fine) eddon disease or condition monary resulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO/OR AS A CONSEQUENCE OF: that initiated events worth resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPS MEDICAL State Carcinomo PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? leti 1 TYES 2 NO ceres 20 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: nt 2 - ER/Outpetient 3 - DOA ne 5 Residence 6 Other (Specify) 27, MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ETED 6 Could not be 4 Homicide COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated INDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. FITLE OF CENTIFIER 29d. DATE SIGNED (Month, Day, Year) BE

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BALTIMORE MARYI AND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760

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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | | F HEALTH AND OF DEATH | MENTAL | HYGIENI REG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | A | n | RI | 66AN | AVAL | OF DEATH | MORE | YEAR S | 7:45 p M |
| | 160 06 0686 | 5. SEX 6. AGE (| 61 yrs. lest birthday) | IF UNDER 1 YE | | | Day, Year) | 933 | Country) | LACE (State or Foreign |
| | Souther May / any | | Contra | 9b. CITY, TO | WN OR LOCATION OF C | EATH | | 9c COU | ITY OF DEA | 4 |
| 2 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | d Hospital | | , TOWN OR LO | Clint | 00 | | 700 | | |
| DIRECTOR | Maryland Princ | ce George's | | on Hi | | | | | - 1 | LIMITS? YES 2 NO |
| FUNEHAL | 100. STREET AND NUMBER 5070 Chester Street | et | | | 10f. ZIP CODE 20745 | 5 | | 10g. CITI Unit | ed S | at country? tates |
| 2 | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 M Divorced | 2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 X NO | If yes | DECENDENT OF NISPA I, specify Cuben, Mexic YES 2 NO Spec | en, Puerto Ri | | or No— | 14. RACE - Black, Specify Whit | - American Indian, White, atc. |
| ED | 15. DECEDENT'S EDUCAT (Specify only highest grade co | mpleted) | 16e. DECEDENT'S U (Give kind of w life. Do NOT use | ork done during | PATION g most of working | 186. | KIND OF BUS | INESS/IND | USTRY | |
| COMPLEI | 10th | College (1-4 or 5+) | Store Cl | , | | C | Conven | ience | Sto | re |
| S I | 17. FATHER'S NAME (First, Middle, Last) George Riggan | | | | Anna Pa | | iddle, Melden S | Sumame) | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Brenda Lee Restey | | 196. MAILING | ADDRESS (Sm | n Road Ro | Route Number | or, City or Town | Stete, Zip | Code) Terse | y, Md 0850 |
| | 20e. METNOO OF DISPOSITION 1 Burlel 2 Notemation 3 Remove | al from State | PLACE AND DATE Of etery, crematory or other | F DISPOSITION | | DATE | | | City or Town | |
| | 4 Donation 5 Other (Specify) | te | e Cremato | orv. A | ug 28,199 | ACILITY T - | | | 1d 20 | |
| | + 98 Foles |) | | | Alexandria | | | | | , Inc 6633 Md 20735 |
| ENITION | 23. PART I Enter the diseases, or conshock, or haert failure. List immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) b | DUE TO (OR AS A | consequence of | THE | E CERL | Vix | | 177 | + | Approximata Interval Between Onset and Daath MONTA |
| MEDICAL | PART II. Other significent conditions of | contributing to death b | ut not resulting in | the underl | ying ceuse given in | - 1 | 24e. WAS AN / PERFORI | WED? | o o | FRE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE IF DEATH? |
| | DID TOBACCO USE CONTRIE | BUTE TO CAUSE O | F DEATH YES | S 🗆 NO | ☑ UNCERTA | N 🗆 | | | | YES 2 NO |
| SICIAN | | IOSPITAL: | | OTHER: | | 400 | 0016 s | | | |
| | 27. MANNER OF DEATN | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. | Home 5 Residence INJURY AT WORK? | _ | (Specify) | JURY OCC | URED | |
| | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | — At home, ferm, at | | YES 2 NO | 281. LOCA | TION (Street or | nd Number | or Rural Rou | te Number |
| | 4 Nomicide determined | building, atc. (Spec | ify) | | | City or | Town, State) | | | |
| | 29e. CERTIFIER (Check only one) 1 M CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: (| | | | | | | | | nd manner as stated. |
| N N | 29b. SIGNATURE AND TITLE OF CERTIFIER | | eu. | | 29c. LICENSE NU | MBER S | 45 | 29d. DATE | SIGNED (A | Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, I | Print) | 11 ~ 1 4 | 207 207 | Oken | tru | 140 | 707112 |
| | 31. DATE FILED (Month, Day, Year) AUG 2 9 1995 | 32. DEGISTRAR'S SIGN | ATURE OF Randally | וחבט | ILIO X | 001 | Urin | Hill | 'V\V | 20145 |

| cian. | Litransit permit Page 1 2 3 should | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--|
| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death, Page 6 may be retained by the hospital or attending physician. | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit Panes 1.2.3 should | | ust be notified at once. | |
| rted within 24 hours after death. Page | completely filled in by the funeral direct | rial, cremation, or removal, | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| quires that the death certificate be exec- | signed by the attending physician and | ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, | ows any injury, or other traumati | |
| ATTENDING PHYSICIAN: The law req | ECTOR: After this certificate has been | led within 72 hours after death with the State Dept, of | RTANT: If Item 28 is marked, or Item 23 sh | |
| TO THE HOSPITAL DR | TO THE FUNERAL DIR | be filed within 72 hour | IMPORTANT: If iten | |

29b. SIGNATURE AND

30. NAME AND AGORESS OF PERSON

Zahir Yousaf,MD

AUG 29

1995

31. DATE FILED (Month, Day, Year)

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. MEGISTHAN WISHGHATURE Rardall

Cenna Center P.O. Box 1289

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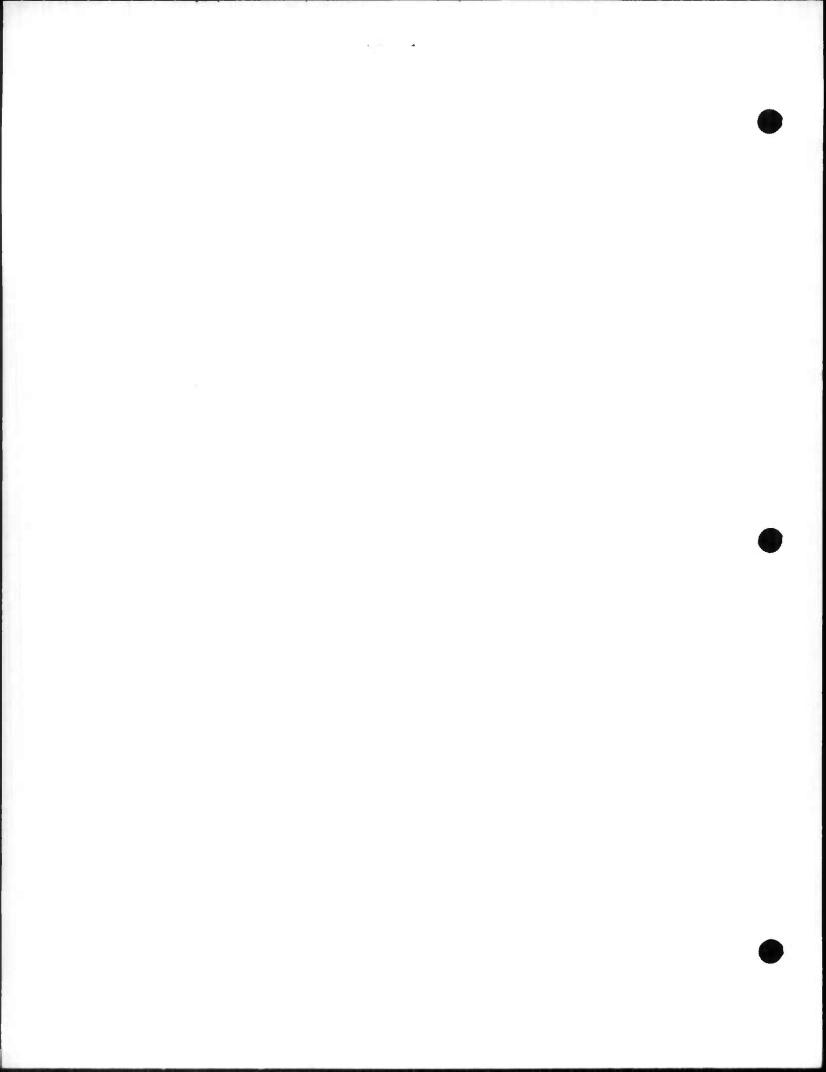
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| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAR | TMENT OF | HEALTH | AND I | MENTAL HYGIEN | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | AY | 3. | TIME OF DEATH |
| | | palding | | | Reynold | 5 | | August 27, 1 | | YEAR 7. | 10 p M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | at birthday) | IF UNDER 1 YEAR | IF UNDER | 1 | 7. DATE OF BIRTH | | A DISTURN | |
| | 219-12-3091 | 1 🗌 M 2 💢 F | 71 | YRS. | MONTHS DAYS | HOURS | MIN. | OCT. 25, | 1923 | Country | 4D |
| l | 9a. FACILITY NAME (If not Institution, give | | | | 9b. CITY, TOWN | OR LOCATI | ON OF DE | ATH | 9c. COUR | TY OF DEAT | тн |
| 6 | Physicians Memorial | Hospital | | | Lap | lata | | | Char | les | |
| ្រួ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Υ | | I too CIT | Y. TOWN OR LOC | TION | | | | | |
| DIRECTOR | MD Cha | rles | | | ulkner | | | | | | INSIDE CITY |
| | 10e. STREET AND NUMBER | | | 1 - 4 | | of, ZIP COD | E | | Tan- OFF | | T COUNTRY? |
| N. | 11675 Edge Hil | 1 Rd. | | | - 1 | | 063 | 2. | 10g. CI11 | U.S. | |
| FUNERAL | 11. MARITAL STATUS | | T EVER IN U.S. AR | MED | 13 WAS D | | | IIC ORIGIN? (Specify Ye | as No. T | | -77 |
| | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE W | YES 2 K | NO | If yes, t | pecify_Qube | ın, Maxica | n, Puerto Rican, atc.) | or No- | Black, W | American Indian, Write, etc. |
| B | 3 Widowed 4 Divorced | 11 123, 0172 | MA ON DATES | | 1 1 11 | S 2 (₹NO | Specify | r: | | Specify: | White |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S | USUAL OCCUPAT | ION | | 16b. KIND OF BU | SINESS/IND | USTRY | |
| Ē | Elementary/Secondary (0-12) | College (1-4 or 5 - | +} /// /// /// /// /// /// /// /// /// / | . Do NOT us | | lost of workii | ng | | | | |
| COMPLET | 12 | | 1 | lome | maker | | | 11 | Home | e | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | 1 1. | | | | | | ME (First, Middle, Melden | | | 1 11 |
| BE | Charles H. Spa | Laing | | | | | • | iolet Ti | | - | alding |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | noldo C | 191 | MAILING | ADDRESS (Street | and Number | r or Flural F | Toute Number, City or Tow | n, State, Zip | Code) | 1622 |
| - | Francis L. Rey | | r. 1 | 110/ | 5 Eage | птт | I K | d. Faulk | | _ | |
| | 20a. METHOD OF DISPOSITION **EXBurial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | STETETY, CAN | Tarry | of disposition (in the State Chu | rch | Cem | . 8/31/9. | CATION — C | ewpor | et, MD |
| 1 1 | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | 20-11415 | ND 10005 | 00 05 54 | DO ATTA | | | TNO |
| | | | | | IAREH | ARTE | F.C.H | OLS FUNE | RAT. | HOME. | INC. |
| | | Elak | | | P.O. | Box | 56 | TES FUNE 7 LaPlat | a,MD | 2064 | |
| Н | 23. PART I. Enter the diseeses, or | complications that | t caused the de | ath. Do n | P.O. | Box | 56 | 7 LaPlata | a,MD | 2064 | Approximate |
| | 23. PART I. Enter the diseeses, or shock, or heart failure. IMMEDIATE CAUSE (Final | complications the List only one ceu | t caused the de se on each line | ath. Do n | P.O. | Box ode of dy | 56' | 7 LaPlata | a , MD | 206 ² | Approximate interval Between |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications the List only one ceu | t caused the de se on each line | ath. Do n | P.O. | Box ode of dy | 56' | 7 LaPlata | a , MD | 206 ² | Approximate interval Between |
| | 23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition | complications the List only one ceu | t caused the de se on each line | ath. Do n | P.O. | Box ode of dy | 56' | 7 LaPlata | a , MD | 206 ² | Approximate interval Between |
| NO | 23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | a. Con OUE TO | t caused the de- ise on each line. PETIVE TOTAL A CONSECUTION | eth. Do r | P.O. He are | Box ode of dy | 56' | 7 LaPlata | a , MD | 206 ² | Approximate interval Between |
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| RTIFICATION | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. Con OUE TO OUE TO C. | t caused the de- se on each line. Petroe as a consecutive (or as a consecutive) | DUENCE OF | P.O. The correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the correction of the co | Box ode of dy | 56' | 7 LaPlata | a , MD | 206 ² | Approximate interval Between |
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29c, LICENSE NUMBER

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Waldorf, MD 20604-1289



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | BIRTNPI | LACE (State or Fo | - |
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| | 9a. FACILITY NAME (If not institution, give st | reet and number) | 9 | b. CITY, TOWN O | R LOCATION OF DE | | , | 9c. COUNT | | | |
| DIRECTOR | 10450 Lottsford | Road | | Mitche | ellville | <u> </u> | | Prin | nce (| George' | S |
| EC | 10a. STATE 10b. COUNTY | | 10c. CITY, 1 | TOWN OR LOCATI | ON | | | | 1 | IOd. INSIDE CITY | |
| | Maryland Prince | e George's | Mi | itchelly | ville | | | | | LIMITS? | |
| FUNERAL | 10e. STREET AND NUMBER | | - | 101. | ZIP CODE | | | 10g. CITIZE | N OF WH | IAT COUNTRY? | 71 |
| Ä | 10450 Lottsford | | | | 2072 | | | US | SA. | | |
| FU | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1 YES | N U.S. ARMED | 13. WAS DECE | ENDENT OF HISPAN | NIC ORIGIN | (? (Specify Yes | or No- 14 | Black, | - American India White, atc. | ın, |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR O | ATES TE | 1 TYES | | | , | | Specify: | | |
| | 15. DECEDENT'S EDUC | CATION | 16a. DECEOENT'S US | UAL OCCUPATION | N | 16h | KINO OF BU | SINESS/INOLIS | | <u>ite</u> | |
| ETI | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of world life. Do NOT use n | k done during mos | t of working | | 10110 01 00 | 51112557111005 | ,,,, | | |
| 1 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 4 | Teache | r | | | Edu | cation | 1 | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, I | Middle, Maiden | Surname) | | | |
| BE | John Carter | | | | Hatti | e May | / Lips | comb | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | d Number or Rural I | | | | | | |
| - | Philip D. Robins | son | 10450 | Lottsfo | ord Rd., | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Buriel 2 Corporation 3 Remo | oval from State 20b | PLACE AND DATE OF I | DISPOSITION (Name | ne of | | E 20c. LO | | | n, State | |
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| | 21. SHAMATURE OF SHAME SERVICE LEG | Walterett | 1 | | Funeral | | e. Inc | | | | |
| | | hews M00658 | | P. O. | box 156 | , Wal | ldorf, | MD 20 | 604- | -0156 | |
| | 23. PART I. Enter the diseases, or c shock, or heart failure. I | ist only one cause on a | ach line | | | | | | | Approxima | |
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| PACING PRESIDENT The Law requires that the death certificate be executed within 24 moust after death. Page 6 may be retained by the hospital or attending physician. | And THE THE CHARGES has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages after that the State Dept. of Health and Membal Highers prior to burial, committee, or namonal. | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s |
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| 2 | TO THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept, of Health and Merital Hypiens prior to burial, comma | MEDIOTANY 14 Hours 50 in secondarial are blown 50 showns and latinate an either beautered to second the secondarial |

296. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)
AUG 2 8 1995

Arthur G. Manalo M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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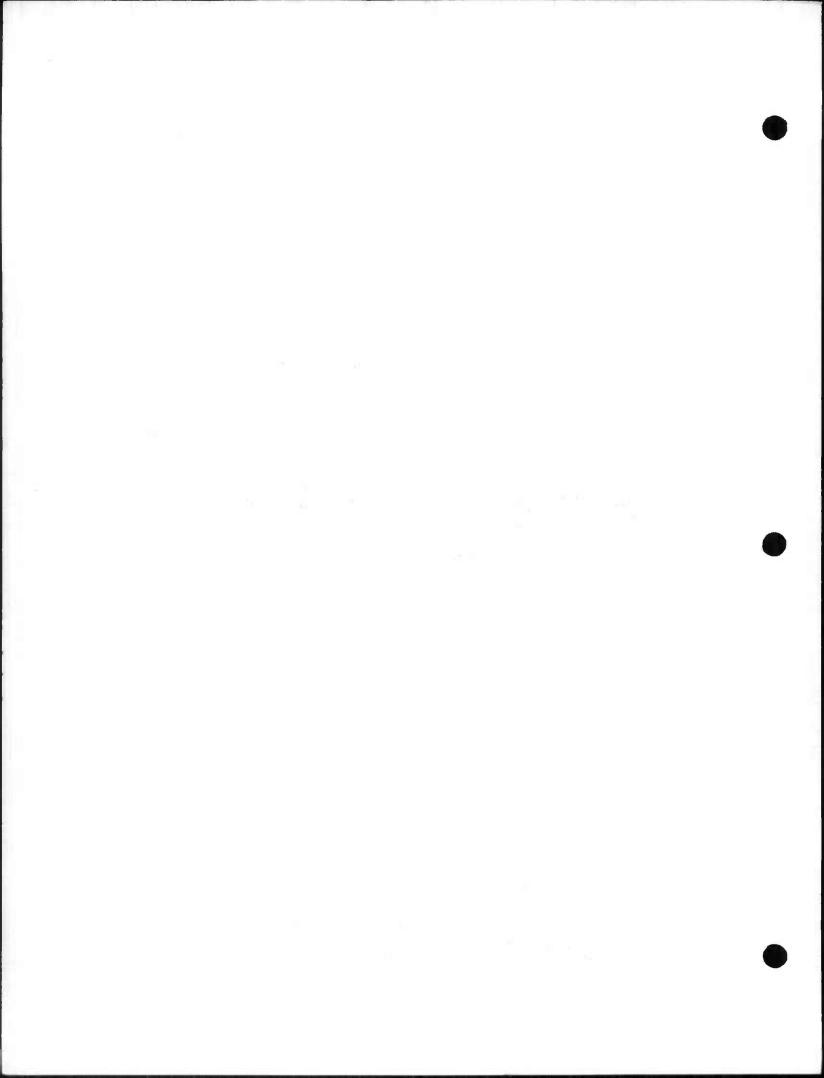
| | 1. DECEDENT'S NAME (First | | RD RAGER | | | | | | | 2. DATE O | - | 7, | 1993 | 3. TIME OF | |
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| | 4. SOCIAL SECURITY NUM | | 5. SEX | 8. AGE (In yrs. I | net hirthring | IE IMOEI | R 1 YEAR | # UNDER | na Amo | Augus | | / , | | 12:3 | _ |
| | 182-14-1726 | | 1X M 2 F | 72 | | MONTHS | DAYS | HOURS | MIN, | Dec. | Day Year) | 1922 | Count | HPLACE (Stote fry) nnsy1v | ar romign |
| | 9a. FACILITY NAME (If not in | | street and number) | | | 9b, CITY | Y, TOWN O | OR LOCATIO | ON OF DE | | 213 | | INTY OF C | | allia |
| | 309 Thomas | | | | | | | deric | | 24111 | | 194 | | erick | |
| | RESIDENCE OF DEC | | | | | | | | | | | | | | |
| | 10a. STATE | 10b. COUNT | | | 200 | ., | OR LOCAT | ION | | | | | | 10d. INSIDE | CITY |
| | Maryland 100. STREET AND NUMBER | | erick | | Fre | ederi | | | | | | | | 1 N YES | |
| | 309 Thomas | | | | | | 101. | . ZIP CODE | | | | 10g. CIT | | WHAT COUNTS | 44.5 |
| Ì | 11. MARITAL STATUS | Avenue | | | | | | | 701 | | | | U.S | | |
| | 1 Never Married 2 | Married | 12. WAS DECEDED FORCES? | YES 2 | NO | | If yes, spe | ecity, Cube | n, Mexica | NC ORIGIN? | Specify Yes an, etc.) | or No- | 14. RAC Blac | E — American ck, White, etc. | Indian, |
| ď | 3 Widowed 4 Divo | proed | IF YES, GIVE | MAR OR DATES | | | 1 TES | 2 Z-NO | Specify | r: | | | Spec | Whit | e |
| | 15. DEC | CEDENT'S EDU | CATION | 16a, C | ECEDENT'S | USUAL O | CCUPATIO | ON | | 16b, K | IND OF BUS | SINESS/IN | • | | |
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| | ll years | | | Fed | leral | Gove | ernme | ent E | Emp1 | руее | None | е | | | |
| | 17. FATHER'S NAME (First, M | | | | | | | | | ME (First, Mic | | Surname) | | | |
| 1 | Joseph C. F | | | | | | | | | Shirk | | | | | |
| | Betty B. Ra | ,, | | 1 | | | | | | Poute Number | | | | 01701 | |
| ı | Delly D. Ka | iger | | | 309 . | Inoma | as At | zenue | Fre | ederio | | _ | and l | 21/01 | |
| -11 | | | | | | | | | | | | | | | |
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| | 20e. METHOD OF DISPOSIT 1 Burial 2 Cremetic 4 Donation 5 Other | FION on 3 Rem r (Specify) | | 20b. PLACE cometery, c | E AND DATE | Te E (| Cemet | tery | 0.05.50 | 8/30 | Free | deri | ck, I | Maryla | |
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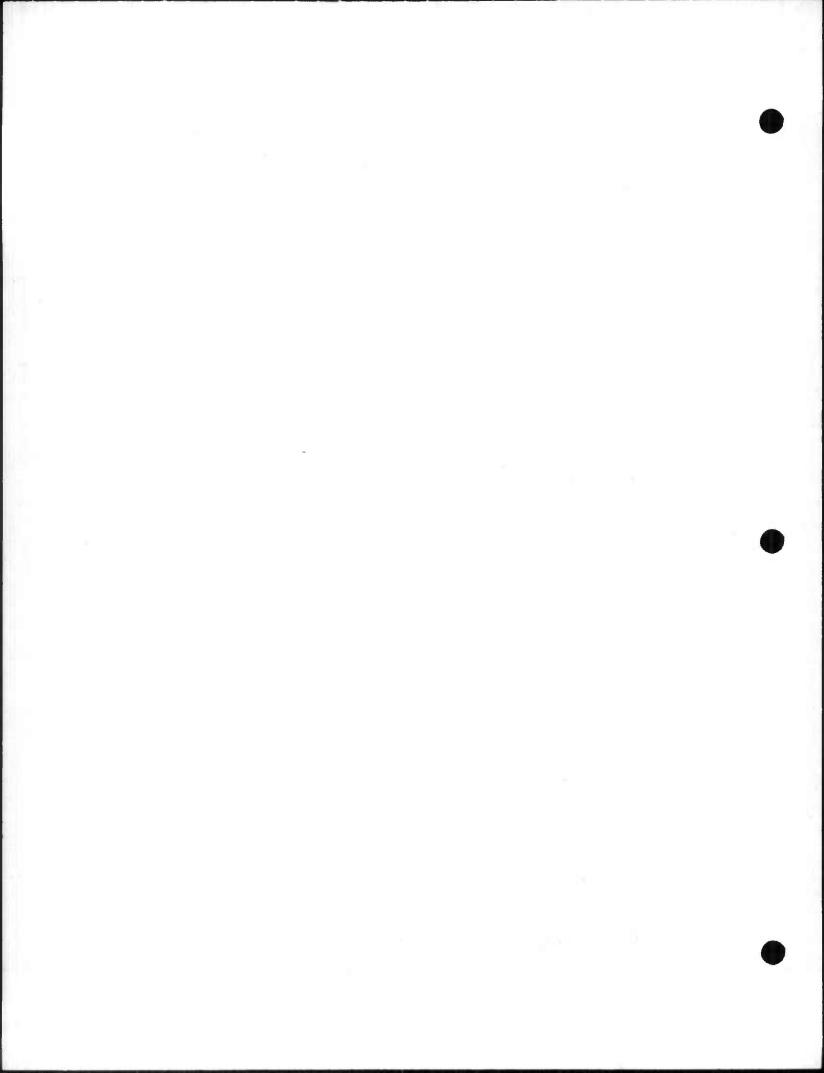
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| ATTE | RECTO! | STANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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95 27182 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME /First Middle Last 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Ruth Naomi Runkles 9:44 August 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 214-10-3882 1 M 2 P F 85 April 910 10, Maryland 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Frederick Memorial Hospital Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Mount Airy 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5212 Woodville Road 21771 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE --- American Indian, Black, White alc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Ric 1 TES 25 NO Specify: BY Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own home. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) BE Daniel Harshman Laura Gaver 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 2 5212 Woodville Road, Mount Airy, Maryland Donald Runkles 20a. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE oval from State 4 Donation 6 Other (Specify) 8/28 Mount Airy, Maryland Prospect Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY Dlin L. Molesworth, P.A., Funeral Home ones Villea d.1 26401 Ridge Road, Damascus, Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition_ Ventimen Fibrillion > 10 mings resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Attue Educhi Cardiovanton Riscon CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEDUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEDUENCE OF) that initiated eventa resulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗵 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | MER/Oulpetient 3 | DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27 MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 26b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. (Check only one) INCAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CENTYIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

0-18171 8-25-95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ATTHER G. MANTED. U.S 187 Thomas Johnson A. Frenchick, mp. 21702

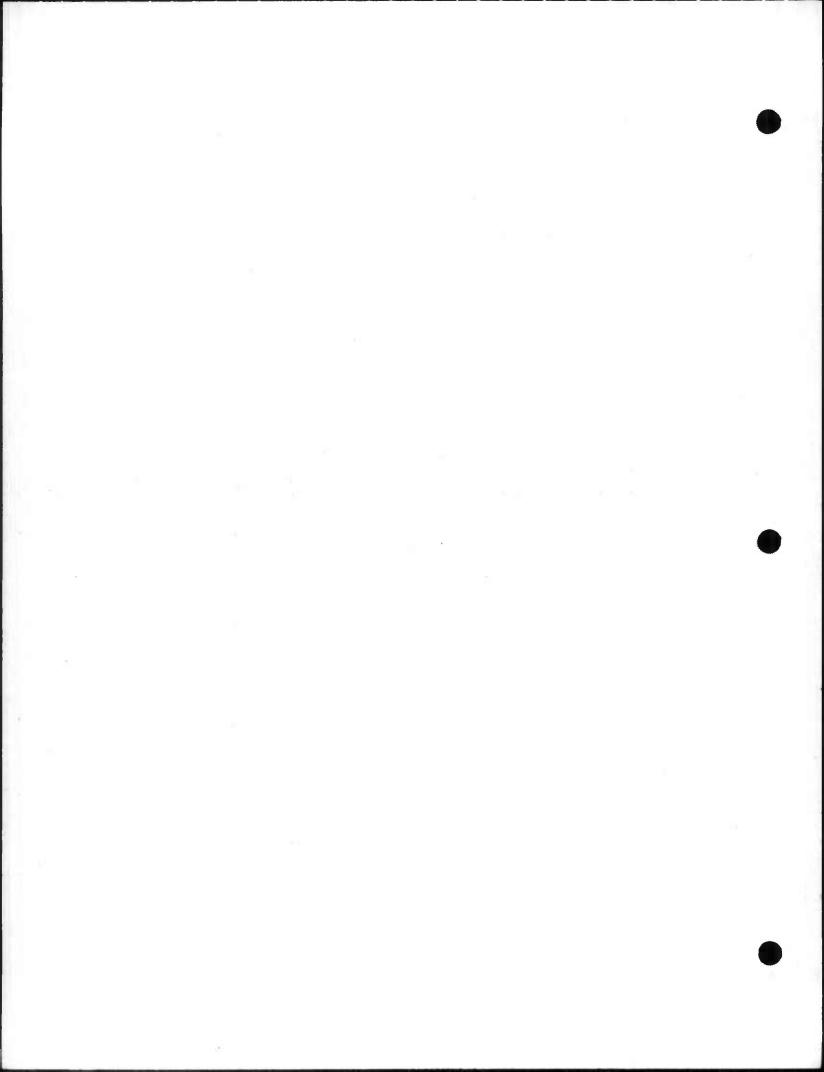
31. DATE FILEO (Month, Day, Year)
AUG 3 0 1995 32. REGISTRAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| DALINGTON OF WITHER RECORDS, F.O. BOA 66/60 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | nd, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| STATE OF ALL PERCURS, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dea | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the att be filed within 72 hours after death with the State Dept. of Health and Menta | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, | |

| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdsy) 9. FACILITY NAME (If not institution, give street and number) 9. FACILITY NAME (If not institution, give street and number) 9. FACILITY NAME (If not institution, give street and number) 9. FACILITY NAME (If not institution, give street and number) 9. FACILITY NAME (If not institution, give street and number) 9. CITY, TOWN OR LOCATION OF DEATH 9. COUNTY 10. STATE 10. COUNTY 10. STATE 10. CITY, TOWN OR LOCATION Maryland Montgomery 10. CITY, TOWN OR LOCATION Maryland 10. STREET AND NUMBER 411 Twinbrook Parkway 11. MARITAL STATUS 11. MARY Married 3. Wildowed 4. Divorced 12. Was DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No) 14. Yes 2. No. Specify: 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. KIND OF BUSINESS/INDUS 17. MAR OF BUSINESS/INDUS 18. DECEDENT'S BUSINESS/INDUS 18. DECEDENT'S BUSINESS/INDU | 10d. INSIDE CITY LIMITS? 1 \(\times YES 2 \(\times \) NO EN OF WHAT COUNTRY? 4. RACE | | | | | | | | | | |
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| 4. SOCIAL SECURITY NUMBER 204-38-7077 1 M 2 F 49 YRS. 49 YRS. 204-38-7077 90. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital Rockville Mont Residence of Decedent 100. STATE 100. STATE 100. STATE 100. STREET AND NUMBER 411 Twinbrook Parkway 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 11. YES 2 (14NO) 14. YES 25 NO Specify: 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 14 Yes, apacity Cuban, Maxican, Puerto Rican, etc.) | L BHRTHPLACE (State or Foreign Country) Pennsylvania Y OF DEATH T GOME TY 10d. INSIDE CITY LIMITS? 1 Y FES 2 NO EN OF WHAT COUNTRY? A. RACE — American Indian, Black, White, stc. Specify: White | | | | | | | | | | |
| 204-38-7077 1 M 2 F 49 YRS. MONTHS DAYS HOURS MIN. JULY 30,1946 F 9e. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital Rockville Mont FRESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Rockville 10e. STREET AND NUMBER 411 Twinbrook Parkway 20851 USA 11. MARITAL STATUS 10c. CITY TOWN OR LOCATION Montgomery Rockville 10f. ZIP CODE 10g. CITIZE 11. MARITAL STATUS 10c. CITY TOWN OR LOCATION 11. MARITAL STATUS 10c. CITY TOWN OR LOCATION 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 (1/2) NO Specify Cuben, Maxican, Puerto Ricen, etc.) 14. Was specify Cuben, Maxican, Puerto Ricen, etc.) 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 1/2) YES 2/2 NO Specify: 1 YES 2/2 NO Specify: | Pennsylvania Y of DEATH Egomery 10d. INSIDE CITY LIMITS? 1 Y ES 2 NO EN OF WHAT COUNTRY? A. RACE — American Indian, Black, White, stc. Specify: White | | | | | | | | | | |
| Shady Grove Adventist Hospital Rockville Mont RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Maryland Montgomery Rockville 10c. CITY, TOWN OR LOCATION Maryland Montgomery Rockville 10f. ZIP CODE 10g. CITIZE 411 Twinbrook Parkway 20851 USA 11. MARITAL STATUS 11. MARITAL STATUS 11. Never Married 21. WAS DECEDENT EVER IN U.S. ARMED FORCES? 11. VES 2 [JHO] 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 14. Yes, specify Cuban, Maxican, Puerto Rican, etc.) 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY, TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 17. Yes 2 [JHO] 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 19. VES 2 [JHO] 10 VES 2 [JHO] 11. VES 2 [JHO] 11. VES 2 [JHO] 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 14. VES 2 [JHO] 15. VES 2 [JHO] 16. CITY, TOWN OR LOCATION NO. CITY 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY, TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION MARYLAND 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vee or No- 16. CITY TOWN OR LOCATION 17. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Vee or No- 18. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Vee or No- 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Vee or No- 19. WAS DECENDENT OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HIS | 10d. INSIDE CITY LIMITS? 1 VES 2 NO EN OF WHAT COUNTRY? 4. RACE — American Indian, Black, White, atc. Specify: White | | | | | | | | | | |
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| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUS | STRY | | | | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | | | | | | | | |
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| 5+ Consultant Energy 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | | | |
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| SO MEROMANTIN NAME CONTROL | inde) | | | | | | | | | | |
| Bonnie L. Ramsey 196. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Yown, State, Zip Co. 411 Twinbrook Parkway Rockville, Mary | | | | | | | | | | | |
| 20s. METHOD OF DISPOSITION 20s I OCATION OF COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY COMPANY CO | No to Your Park | | | | | | | | | | |
| Gate of Heaven Cemetery 8/21/95 Silver Sp | ring, Maryland | | | | | | | | | | |
| 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Ho | ome, Inc. | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. Liet only one cause on each line. | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition | Interval Between Onset and Death | | | | | | | | | | |
| resulting in death) DUE TO (OR AS A CONSCOUENCE OF): | 7440 | | | | | | | | | | |
| Sequentielly list conditions. To Metastate hung Caren - Aderocaren | ma years | | | | | | | | | | |
| If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| resulting in death) LAST | | | | | | | | | | | |
| PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | |
| DEDECORAGE | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | |
| 1 YES 2 NAO | OF DEATH? | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 S. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 MAO THER: 1 YES 2 MAO OTHER: 1 YES 2 MAO 28. INJURY AT 28d. DESCRIBE HOW INJURY OCCUP (Month, Day, Year) NAURY WORK? | 10,120 20,110 | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | |
| 1 YES 2 NO 1 Inputiont 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 7. MANNER OF DEATH 28e, DATE OF INJURY 28h TIME OF 28e INJURY AT 194 DESCRIPTION OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF TH | | | | | | | | | | | |
| 2 Accident Investigation M 1 YES 2 NO | RED | | | | | | | | | | |
| | Rural Route Number, | | | | | | | | | | |
| 3 Suicide 4 Homicide 5 Could not be determined 28f. LOCATION (Street end Number or City or Town, State) 29c. CERTIFIER (Check only orie) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner as stated. | couse(e) and menner se stated. | | | | | | | | | | |
| 296. SIGNATURE OF CERTIFIER 29d. DATE S 29d. DATE S | BIGNED (Month, Day, Year) Mary 17 1995 | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN S NEWMAN | 1 11/11/3 | | | | | | | | | | |
| 19261 Montgamery Vill. Ave. Gar thers burg, Mary land 2 | 2879 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 22. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| AUG 21 1995 Julia Davideon Rendell | | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

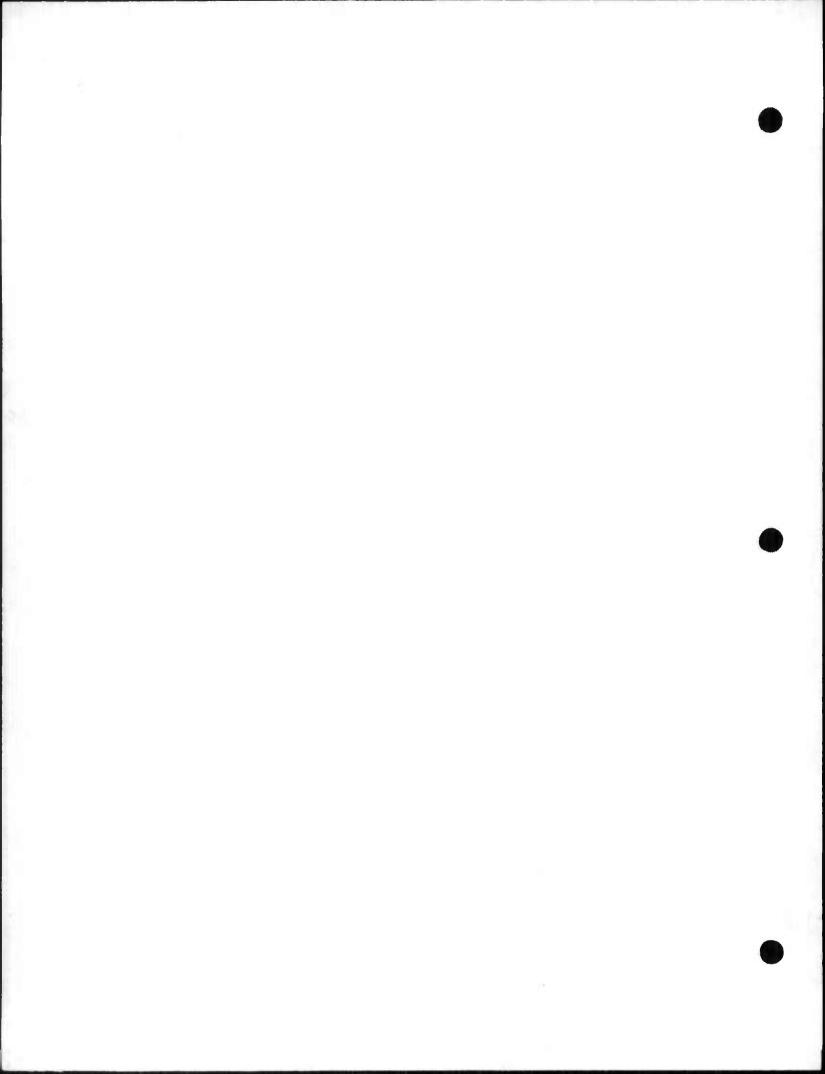
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | AND / DEPARTM | | | MENTAL HYGIE | | | | | | |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------|---------------------------------------------------|---------------------------------------------|----------------|--------------------------------|----------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Lester Ra | | | | 2. DATE OF DEATH MONTH August 24 | YEAR | 3. TIME OF DEATH 6:25 A M | | | | |
| | 4. SOCIAL SECURITY NUMBER 218-38-6834 | _ | (In yrs. last birthday) | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Oct. 6, | | 8. BIRTHP Country) | LACE (State or Foreign | | | |
| OR | 90. FACILITY NAME (If not institution, give to 9 Landsend Drive | street and number) | 96 | | ersburg | | 9c. COUN | Montgomery | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Mont | tgomery | | TOWN OR LOCAT | | | | 10d, INSIDE CITY LIMITS? | | | | |
| | 10a. STREET AND NUMBER 9 Landsend Drive | | 1 6 | aithers | ZIP CODE | | | 1 ☑ YES 2 ☐ NO HAT COUNTRY? | | | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 X Married | 12. WAS DECEDENT EVER FORCES? 1 X YES | | | | NIC ORIGIN? (Specify Y | | 14. RACE - | States - American Indian, White, atc. | | | |
| BY | 3 Widowed 4 Divorced | 1960-1963 | | 1 TES | 2 X NO Specif | y: | | Specify | | | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of work life. Do NOT use n | k done during mo: etired.) | at of working | Heatin | | | onditioning | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Lester Ratlif | ef, Sr. | | | | ME (First, Middle, Maide Elizabeth | on Surname) | | , indicated and in the second | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) E. Sue Ratliff | | | | nd Number or Rural | Route Number, City or To | wn, State, Zip | Code) | 1 20878 | | | |
| | E. Sue Ratliff 9 Landsend Drive, Gaithersburg, Maryland 20e. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place AND DATE of DISPOSITION (Name of cemetory, crematory or other place) August 26, 1995 Rockville, Ma | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | and | M00198 | Rober 300 Rock | ADDRESS OF FA T A. Pun West Mor VIIIe. N | nphrey Fun tgomery A laryland | eral H | Home/ | Rockville, | | | |
| CERTIFICATION | 23. PART I. Enter the filesesses, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) End Stage Renal Disease Due to (or as a consequence of): Hypertension Due to (or as a consequence of): CAUSE (Disease or injury | | | | | | | | | | |
| A | PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Performed? 1 Ves 2 No. | | | | | | | | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | | | UNCERTAI | N D | | 1 | □ YES 2 😡 NO | | | |
| YSICI | EXAMINER? 1 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Out | | THER: | 5X Residence | 6 C Other (Specify) | | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME O INJURY | M 1 N | IRY AT NK? ES 2 NO | 28d. DESCRIBE HOW | INJURY OCC | URED | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, etc. (Spe | f — Al home, lerm, stree city) | et, factory, office | | 261. LOCATION (Stree City or Yown, Stat | | or Rural Roo | ute Number, | | | |
| COMPLETED | | ICIAN: To the best of my know ER: On the basis of examination | | | | | | | and manner as stated. | | | |
| TO BE | 296. SECRETURES AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH | laws, | Y. O EATH (ITEM 27) (Type, Pri | nt) | 29c. LICENSE NUN D323 | | | | Vonth, Dey, Year) 24, 1995 | | | |
| | Alison Norris, M 31. DATE FILED (Month, Day, Year) AUG 25 1995 | | Research B | | ockville | e, Marylar | ıd 208 | 850 | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760



| | signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should | |
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| requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician. | en s | 00 P |

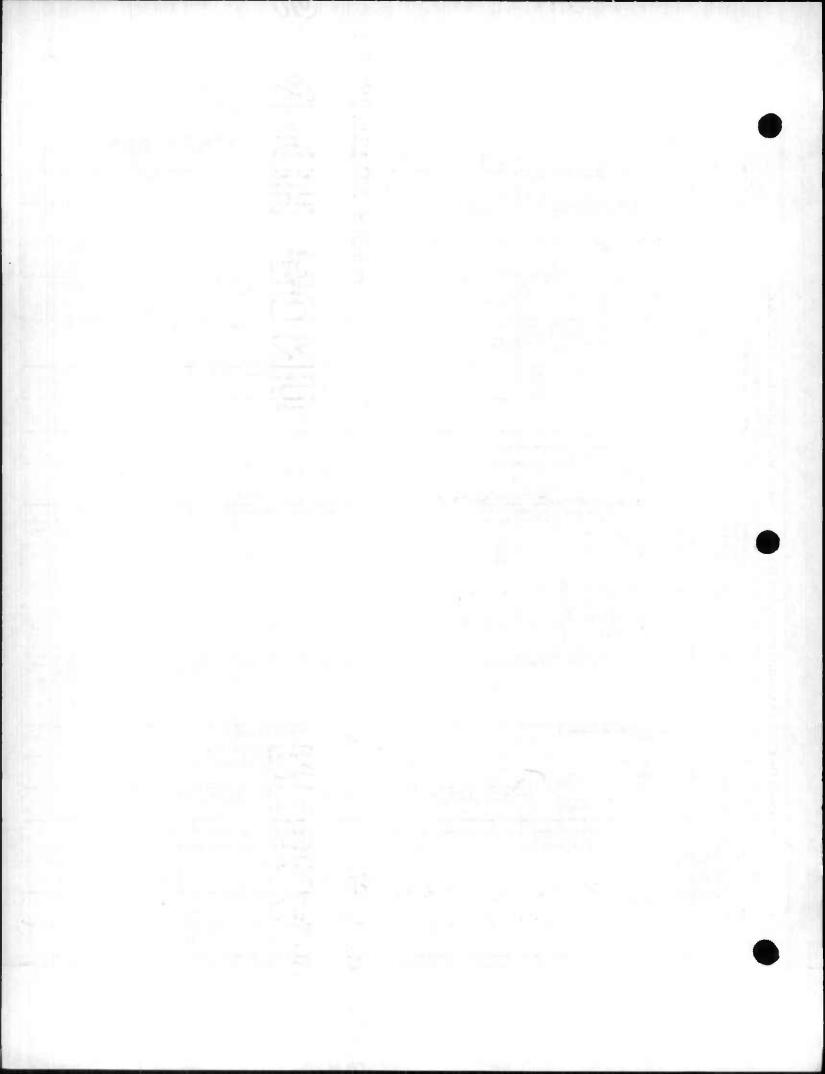
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTHAR | | CERTIF | ICALE OF | DEATH | REG. NO | O | | | |
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| - (| 1. DECEDENT'S NAME (First, Middle, Last) ROBER | r D DA: | מת | 14 | | 2. DATE OF DEATH | DAY 100F | 3. TIME OF OEATH | | |
| | A. SOCIAL SECURITY NUMBER | | PP GE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2. DATE OF BIRTH | AUGUST 20,1995 YEAR 8: | | | |
| | 320-26-2495 | 1 M 2 D F | 66 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) JANUARY 1 | 1727 | BIRTHPLACE (State or Forei Country) | | |
| 3 | Se. FACILITY NAME (If not institution, give | 41 | 00 | 9b. CITY, TOWN | OR LOCATION OF D | | 9c. COUNTY | 11inois | | |
| Œ | MANOR CARE OF | | | | Y CHASE | CAITI | | MONT. | | |
| 6 | RESIDENCE OF DECEDENT | DETITION | | CILLY | I CHASE | | 1 | MONT. | | |
| DIRECTOR | 10a. STATE 10b. COUNT | Υ | | Y, TOWN OR LOCA | | | | 10d. INSIDE CITY LIMITS? | | |
| - | D.C. | | Wa | ashingto | n | | | 1 X YES 2 N | | |
| ₹ | 104. STREET AND NUMBER | | | 10 | of. ZIP CODE | | - | OF WHAT COUNTRY? | | |
| FUNERAL | 4201 Cathedral | | | | 20016 | | U.S | .A. | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVEN FORCES? 1 X 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | res 2 No | If yes, a | DECEMBERT OF HISPAL Pecify Cuben, Mexico S 2 X NO Specific | NIC ORIGIN? (Specify Wan, Puerto Rican, etc.) by: | na or No— 14 | . RACE — American Indian Black, White, etc. Specify: White | | |
| | 15. DECEOENT'S EDU | CATION | 16a. DECEDENT'S | USUAL OCCUPAT | ION | 16b. KINO OF BI | USINESS/INDUS | | | |
| Ħ | (Specify only highest gradi Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | work done during no se retired.) | lost of working | | | | | |
| AP. | | 4 | Manage | er | 155 | 3M Co | ompany | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | UTTAL | | AME (First, Middle, Maide | | TO PERSON | | |
| BE (| Francis Joseph | Rapp | | | Kathe | rine Redin | ng | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or To | | | | |
| - | Mary R. Rapp | | 4201 | Cathedra | l Avenue | , N.W. Was | shingto | n, D.C. 200 | | |
| | 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 🏋 Cremation 3 ☐ Ran | noval from State | 20b. PLACE AND DATE | OF DISPOSITION (A | lame of | | | ATION — City or Town, State | | |
| | 1 Burlai 2 Cremation 3 Removal from State Commelter, crematory or other place A Donation 5 Other (Specify) Mount Comfort Crematory 8/24 Alexandr 22. NAME AND ADDRESS OF FACILITY JOS GAWLERS STATEMENT A Complete place Crematory B Cremat | | | | | | | | | |
| | 21. SIGNATURE OF TUNERAL SERVICE LI | CEMBER |) | | | JOS GA | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | |
| | PART II. Other algoriticant condition | d | ng cause given in | Part I. 24a. WAS A | N AUTOPSY | 24b. WERE AUTOPSY FIN | | | | |
| MEDICAL | | PRMED? | MAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. 1 | PLACE OF DEATH (C) | neck only one) | | | | |
| SIC | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/ | Outpatient 3 DOA | OTHER: | me 5 - Residence | 5 Other (Specify) | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJU (Month, Day, Ye | JRY 20b. TIN ear) IN. | JURY W | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCUP | RED | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28s. PLACE OF INJ butlding, etc. (| JURY — At home, ferm, (Specify) | atreet, fectory, offi | ce | 281. LOCATION (Street City or Town, State | | Rural Route Number, | | |
| COMPLETED | onei AL | IICIAN: To the best of my k | | | | | | | | |
| BE C | 296, SIGNATURE AND TITUE OF CERTIFIE | * // | 1/ | / | 29c. LICENSE NU | | | IGNED (Month, Day, Year) | | |
| 5 | 36. NAME AND ADDRESS OF PERSON WI | HO COMPOSTED AUSE OF | DEATH (ITEM 27) (Type | Print) | D 0417 | 9 | AUG | UST 21,1995 | | |
| | JAMES J. FOSTER | | WISC. AVE | . #925 | CHEVY CHA | SE, MARYL | AND 208 | 315 | | |
| | 31. DATE FILED (NOTE). Day, Year) | 32 REGISTRAR'S | BIGNATURE | | | | | | | |
| | 7 1000 | | | | | | | | | |

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FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Au Gust 5:17 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR 587 62 3160 44 1 AM 2 F DAYS HOURS Nov.5,1950 Escatawpa, MS Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH SOUTHERN IN DIRECTOR GEORGE 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington, D.C. permit. 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? infeate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit in phor to burial, qefillating, or removal. 3536 Clay Pl., N.E. 20019 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 XNO Specify: 1 Never Married 2 Married Specify: Black BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Supervisor Park Hyatt Hotel once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Willie D. Reeves notified at Mary Marion BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code, 9 Tommy Reeves 3536 Clay Pl., N. E., Washington, D.C. 20019 ě 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Cemetery, cremetory or other place)
The Baptist Cemetery 8/21/95 4 Donation 5 Other (Specify) Escatawpa, traumatic event, the medical examiner FUNERAL SERVICE LICES 22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between abock, or heart fallure. List only one cause on each line. IMMEDIATE/CAUSE (Final **Onset and Death** Candia Palmani disease or/condition Nuca resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Miner de CERTIFICATION Sequentially ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury Vo Coulor Nya Paty the attending physician Mental Hygiene prior to the death certificate be 1201 other t DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO has been signed by the Oept. of Health and I shows any COMPLETION OF CAUSE 1 YES 2X NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) r this certificate h h with the State (HOSPITAL:
1 Pinpetient 2 ER/Outpetient 3 DOA 1 YES 2 NO Home 5 - Residence 8 - Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO L DIRECTOR: After the hours after death w BY OR ATTENDING 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 65 3 Suicide COMPLETED 6 Could not be 28 4 Homicide Item 29e. CERTIFIER (Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL OF THE FUNERAL EDGE FILED WITHIN 72 HIMPORTANT: If II 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 200. BIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 25640 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SLOW AUACKI 32. REGISTRAR'S SIGNATURE alin Davides Revolate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

- 1995

9c. COUNTY OF DEATH

1956

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Wilson, N.C.

14. RACE — American Indian, Black, White, etc.

Black

10d. INSIDE CITY

1XXYES 2 NO

20019

D.C.

Approximate

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

8-18-95

COMPLETION OF CAUSE

Interval Batween

Onset and Death

Prince George's

10g. CITIZEN OF WHAT COUNTRY?

United States

Wilson, N.C.

6:20 A. H

REG. NO

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year, Feb. 3,

8

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DIVISION OF VITAL RECORDS, P.O. BOX

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Jutton

1 M 2 - F

5. SEX

6. AGE (In yrs. last birthday)

YRS.

39

Freddie

4. SOCIAL SECURITY NUMBER

241-94-5492

1 -

Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWH OR LOCATION OF GEATH DIRECTOR Hyattsville Nursing Home Hyattsville RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION District of Columbia Washington permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 4110 Ames Street, N. E. use as the burial-transit 20019 attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Married 2 Married BY 3 Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) 9 be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) hospital COMPL 12 Driver Private once. 17. FATHER'S NAME (First, Middle, Last) the 18. MOTHER'S NAME (First, Middle, Melden Surname) notified at Cleveland Carter Z B Nina Sutton funeral director, page 5 should retained 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Jessie L. Harris 5362 East Capitol Street, N.E., Washington, Page 6 may be 3 20a, METHOD OF DISPOSITION
1 X Burial 2 ☐ Cremetion 3 ☐ Ren 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Rest Haven Cemetery

Rest Haven Cemetery 4 Donation 8 Other (Specify) 8/26/95 examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE STEWART FUNERAL HOME 4001 Benning Road, N.E., Washington, D.C. the 1 medical 23/ PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, completely filled in by shock, or heart failure. List only one cause on each line. 6 IMMEDIATE CAUSE (Finel the cremation, disease or condition ardio Pulmonary
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) traumatic event, signed by the attending physician and con Health and Mental Hygiene prior to burial, Jepsin CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate Recurrent cause. Enter UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 6 any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Injury 1 TES 2 NO Shows t. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X PHYSICIAN: UNCERTAIN [has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The After this certificate death with the State HOSPITAL: OTHER:
4 Nursing Home 5 - Residence 8 - Other (Specify) 1 TES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 6 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO M BY Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 90 ETED 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: hours after 4 Homicide 28 Hem 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as atsted. COMPL TO THE HOSPITAL OF TO THE FUNERAL DE FIED WITHIN 72 M HOSPITAL MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE me to 2 ME AND MORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Beltsville Md. 20705 Jones MD 11305 Pitsea Dr. Gary

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

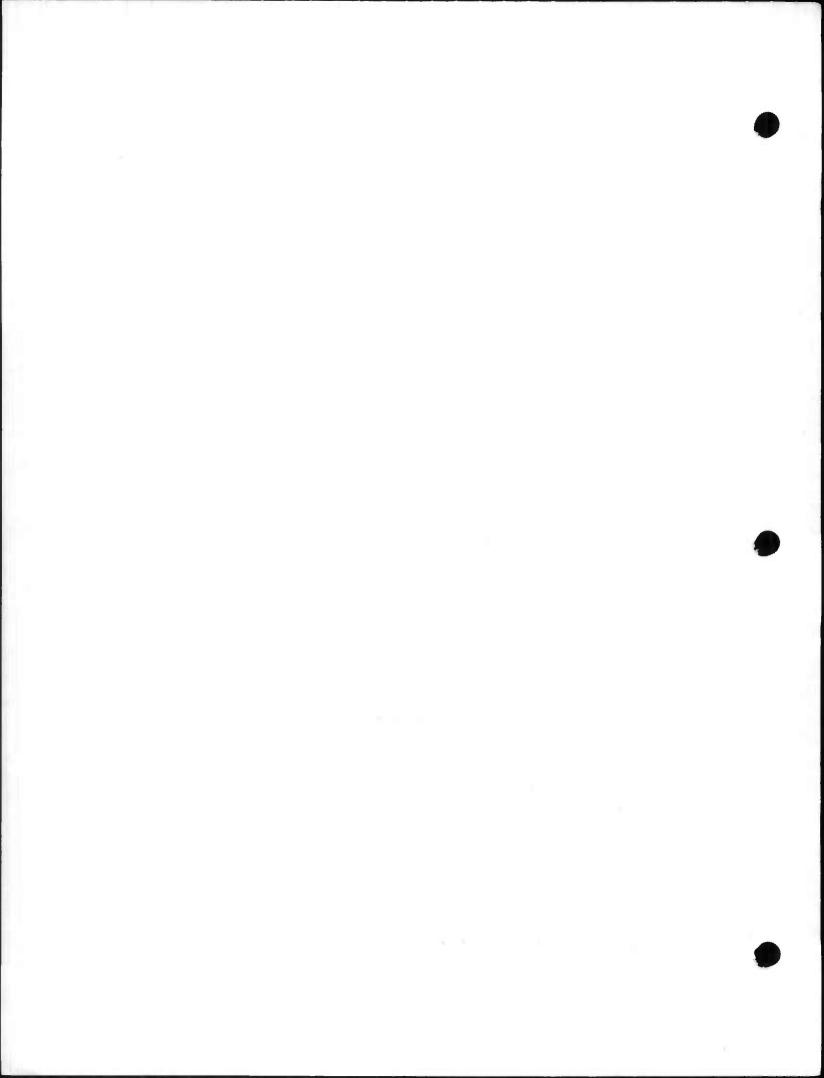
IF UNDER 24 HRS.

HOURS

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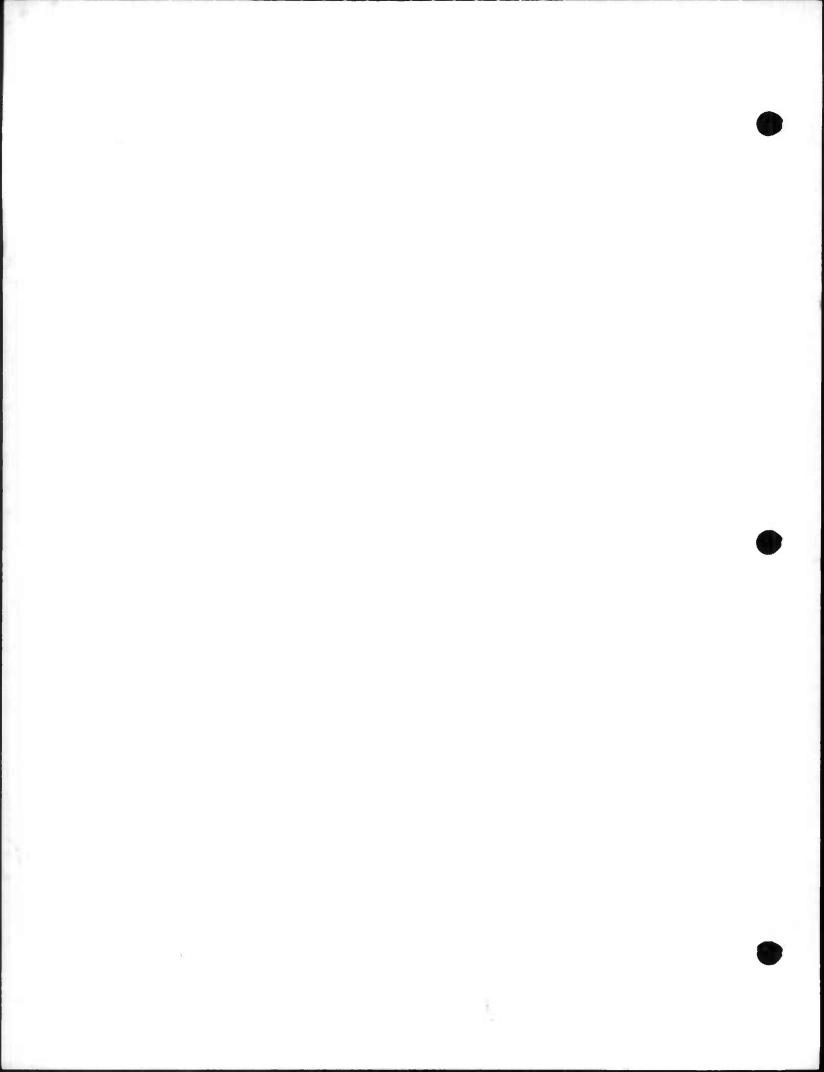
| | 1 - STATE REGISTRAR | STATE OF MARY | | | F HEALTH AND OF DEATH | MENTA | REG. NO. | | | | | |
|-------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------|----------------------------------------------------|-----------------|--------------------------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | 11) | | | | 2. DATE | OF DEATH | , ve | 3. TIME OF DEATH | | | |
| | Simms Jo | ho W. | | | | AUGUST 21 1995 | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | E (In yrs. last birthday) | IF UNDER 1 YEA | | 7 DATE | OC BIOTH | 8.1 | BIRTHPLACE (State or Foreign Country) | | | |
| | 578-03-2513 | | 6 YRS. | | | | 15,18 | | ryland | | | |
| œ | 9a. FACILITY NAME (If not institution, give | | | | WN OR LOCATION OF | DEATH | | 9c. COUNTY | | | | |
| 1 6 | LORIEN NURSING H | 10ME | | Columb | oia | | | Howard | <u>a</u> | | | |
| DIRECTOR | 10e. STATE 10b. COUN | _ | | TY, TOWN OR LO | | | | | 10d. INSIDE CITY LIMITS? | | | |
| | MD Howa | ara | 0 | olumbia | 1 | | | ₹NEX YES 2 □ NO | | | | |
| ERAL | 10s. STREET AND NUMBER | | | | 101. ZIP CODE | | | _ | OF WHAT COUNTRY? | | | |
| FUNE | 6334 Cedar Lane | 12. WAS DECEDENT EVER | INTIS ADMED | 12 446 | 21044 | ANIC OBICI | 12 /0 W. W | | SA | | | |
| BY | 1 Never Married 2 Married | FORCES? 1 YE | S 2 NO | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Spec If yea, specify Cuban, Maxican, Puarlo Rican, ¢ 1 ☐ YES 2 🏋 NO Specify: | | | Ricen, etc.) | | RACE — American Indian, Black, White, etc. Specify: White | | | |
| | 15. DECEDENT'S EC (Specify only highest gra | | | | | | KIND OF BUS | INESS/INDUST | | | | |
| Ä | Elementary/Secondary (0-12) | College (1-4 or 5+) | 120 | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | |
| once. | 12 17. FATHER'S NAME (First, Middle, Lest) | | Salesp | erson | | | | | Industry | | | |
| a o | Francis Simms | 3 | | | | | AME (First, Middle, Malden Surname) ine Shorter | | | | | |
| 3 0 | 19a. INFORMANT'S NAME (Type/Print) | , | 19b. MAILIN | G ADDRESS (Str | eet and Number or Run | | | | io) | | | |
| | Robert Simms | | 5837 | Hunt | Hill Dr | .,E1 | kridg | e, MD | 21227 | | | |
| st pe | 20a. METHOD OF DISPOSITION XX Burial 2 Cremation 3 Re | | 0b. PLACE AND DATE | OF DISPOSITION | N (Neme of | DAT | | | or Town, Stata | | | |
| r must | 4 Donation 5 Other (Specify) | | Cedar H | | emetery | | 24 Sui | | | | | |
| examiner | 21. SIGNATURE OF FUNERAL SERVICE | eral H | | Inc. and,MD 20746 | | | | | | | | |
| medical | 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | |
| t, the | disease or condition | | | | | | | | | | | |
| event, | | DUE TO (OF AS | A CONSEQUENCE (| OF): | | | | | | | | |
| RTIFICATION | Sequentially list conditions, if sny, lesding to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | | |
| . S | | | | | | | | | | | | |
| T H | that initiated events | DUE TO (OR AS | A CONSEQUENCE O | OF): | | | | | | | | |
| | resulting in death) LAST | | | | | | | | | | | |
| DICAL CE | PART II. Other significant condition | ons contributing to death | but not resulting | in the under | ying causa given i | in Part I. | 24a. WAS AN A | | 24b. WERE AUTOPSY FINDINGS | | | |
| E C | | | | | | | 1 TES 2 | | AMRILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| shows an | NID TODACCO LICE | CONTRIBUTE TO | CALLER OF | SPIEIT | 1/84 88 17 | | | | 1 TES 2 1 NO | | | |
| 69 1.0 | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | | | - | | | | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | QTHER: | 8. PLACE OF DEATH (| Check only or | 10) | | | | | |
| 14S | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpetiant 2 ER/O | | | Home 5 Residenc | | | HIPV OCCUPA | | | | |
| -X 1 | 1 Netural 5 Pending | (Month, Day, Year | | JURY | WORK? | 200. DE: | SCRIBE HOW IN | JUNY OCCURE | 20 | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not b | 28e. PLACE OF INJU | RY — At home, farm, | | | | | nd Number or R | lural Route Number, | | | |
| 2 H | 4 Homicide determined | | эвспу) | | | City | or Town, State) | | | | | |
| Item PLE | 29a, CERTIFIER (Check only 1 CERTIFYING PHY | YSICIAN: To the best of my known | owledge, death occur | red at the time, | deta and placa, and d | us to the car | use(a) and mane | ner as stated. | | | | |
| ANT: If Ite | | NER: On the beals of examinat | | | | | | | use(a) and menner as stated. | | | |
| EU | 296. SIGNATURE AND TITLE OF CERTIFIE | HER / | / | | 29c. LICENSE N | IUMBER | | 29d. DATE SK | GNED (Mogth, Day, Year) | | | |
| 0 B | | Rey / Will | 3/2 | | D500 | 150 | | > 8 | 155182 | | | |
|) | 30. NAME AND ADDRESS OF PERSON V | UT 3460 | Ellevel | f- Conte | · boy L | Fllect | 1 Cit | y he | 1 21043 | | | |
| | AUG 24 1995 | 32 REGISTRAR'S SIG | GNATURE | - | | | | 1 | | | | |
| | , 10 d N + 1000 | | | | | | | | | | | |



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | | | | | | 10/1/12 | - 01 | DEATH | MEG. NO | | | | | |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------|-----------------------------------------|-------------------------|------------|-------------------------------------------------------------|----------------------------------------------|-------------------|---------------|--------------------------------------------|--|--|
| | | , | 1. DECEDENT'S NAME (First, Middle, Last) SARAH | RICHARD | SON SI | MAT.T. | MOOD | | | 2. DATE OF DEATH MONTH | AY A A F | YEAR | 3. TIME OF DEATH | | |
| | | H | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | | IF UNDER | 4 4540 | | 7. DATE OF BIRTH | 1995 | | В. Э- И | | |
| | | | 579-50-9345 | 1 M 2 X F | 58 | YRS. | MONTHS | DAYS | HOURS MIN. | 2/9/193 | 7 | Wasr | LACE (State or Foreign | | |
| plnous | | 1 | 9a. FACILITY NAME (If not institution, give st | reet and number) " | 500 E | orosi | 9b. CITY, | , TOWN | OR LOCATION OF DE | | | ITY OF DE | | | |
| 2, | 2 | | HOLY CLOSS HO | spitalĠ | Ien R | oad | S: | ilv | er Spri | ng | | tgom | | | |
| | [| } | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY | | | 10c CF | TY TOWN O | DR LOCA | TION | | | | | | |
| permit. Pages 1, | | Holy Cross HospitalGlen Road Silver Spring Mon RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Washington | | | | | | | | | | - 1 | IOd. INSIDE CITY LIMITS? YES 2 \[\] NO | | |
| perm | | | 10e. STREET AND NUMBER | | 10f. ZIP CODE | | | | | | 10g. CITIZEN OF V | | | | |
| n. ansit | 1 1 1 | | 1817 Goodhope | e Road S.E. 20020 | | | | | | | | US | A | | |
| MARYLAND 21215-0020 retailed by the hospital or attending physician. 5 should be detached for use as the buria-transit | RV FIINERAL | - 11 | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 XDivorced | 12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W | YES 2 | ARMED NO | 1 1 | If yes, sp | CENDENT OF HISPAN secify Cuben, Maxica 3 2 NO Specify | IC ORIGIN? (Specify Yes, Puerto Rican, etc.) | or No- | Black, | - American Indian, White, atc. Black | | |
| 15 tendi | | | 15. DECEDENT'S EDUC | ATION | 160 | OECEDENT'S | I IISIIAI OO | CCUBATI | ON | 164 KIND OF BUI | 1 | | | | |
| D 2121 spital or att | Once. | | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+ 2yrs | | (Olve kind of life. Do NOT u Clei | work done one retired.) | during mo | ost of working | U.S. Postal | | Services | | | |
| AND the hospits detached | Once. | | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTHER'S NAI | ME (First, Middle, Maiden | Surname) | - | | | |
| YL By | 11 m | | Dock S. Rich | | | | | | Sarah | Gaffney | | | | | |
| MARYLAND retained by the hospid 5 should be detached | TO BY | | the fact of the first of the fi | Smallwo | od | 19b. MAILING | AODRESS | (Street s | and Number or Rural F | Mariber, City or Tow | n, State, Zip | Code) | | | |
| be 5 | 5 P | - | Carlon . El | | | 332 | E. I | Dia | mond Av | e,Gaithe | rbur | g,MD | | | |
| BALTIMORE, I after death. Page 6 may be by the funeral director, page moval. | must | | 20a. METHOD OF DISPOSITION Fig. Burlel 2 Cremation 3 Remo 4 Donation 6 Other (Specify) | ovel from State | 20b. PLAC | E AND DATE | of Disposi | ori | al Park | 0ATE 20c. LO 8/26/95 | cation = c | over | , MD . | | |
| TIN Pag | examiner | į. | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 0 | | 22. 1 | NAME A | ND ADDRESS OF FAC | ster Fun | oral | Hom | | | |
| death death | exa | 21. SIGNATURE OF FENERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral 1 3605 14th St. N.W. Wash | | | | | | | | | | | . 20010 | | |
| | medical | 23. PART I. Enter the dispases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | | | | |
| filled in the | | | shock, or Webrt fellure. I | list only one ceu | se on each li | ne. | | | | | | | Interval Between Onset and Death | | |
| within 4 | # | | disease or condition resulting in death) a. ACUTE WONDCYTIC LEUKEWIA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 3760 ried within completely ial, crematil | Ven | | | | | | | | | | | | 100 | | |
| BOX 68760 ate be executed with sysician and complet prior to burial, crer | or other traumatic event, the | | | | | | | | | | | | 8000 | | |
| BOX ate be ex hysician a | r other traumatic | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that insisted expensions) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | |
| i, P.O. BOX leath certificate be attending physician | P C | | | | | | | | | | | 1240 | | | |
| Certific O | to E | | that initiated evants resulting in death) LAST | 502 101 | ON AS A CONS | EODENCE O | · . | | | | | | | | |
| 10 0 0 | | | | | | | | | | | | | | | |
| # # P | DICAL C | | PART II. Other algnificant conditions | contributing to | deeth but not | resulting | in the un- | deriyin | g cause given in i | Part I. 24e. WAS AN | | | VERE AUTOPSY FINDINGS | | |
| L RECOR | | | | | | | | | | 1 YES 2 | NO | C | OMPLETION OF CAUSE OF DEATH? | | |
| N requir | shows: | | 212 722 4 222 4 22 | | | | | | | | | 1 | ☐ YES 2 ☐ NO | | |
| VITAL RING IN The law revicate has been State Dept. of | S Z | | DID TOBACCO USE CONTR | RIBUTE TO CA | | | | | UNCERTAIN | | | | | | |
| OF VITAL PHYSICIAN: The law this certificate has with the State Dep | E C | | EXAMINER? | HOSPITAL: | | ACE OF DEA | OTHER | 1: | 100 - | | | | | | |
| F V | 5 × | | 1 TYES 2 V NO | 1 Impetiant 2 28a. DATE OF | | 3 DOA | | | e 5 Residence | | | | | | |
| O \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | - | 1 Natural 5 Pending | (Month, De | | IN. | JURY | | PRK? | 28d, DESCRIBE HOW I | NJURY OCC | URED | | | |
| ONG OING death | | _ | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE OF | INJURY - AL | home, farm. | atreet, facto | | | 28f. LOCATION (Street a | and Mumbus | ne Church Day | do Mumbos | | |
| ISI TEN TOR: | 00 III | = (| 3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) | | | | | | | | ind Hamber (| or nurer noc | ne Number, | | |
| DIV OR A DIREC hours | MPLET | | 90. CERTIFIER A CERTIFVINO PHYSIC | TAN: To the heat of | - kasulada | 4 | | 7 75 | 12,000 | | | | | | |
| 절절 점 | | | (Check only one) 1 (CERTIFYINO PHYSIC ONE) 2 MEDICAL EXAMINER | | | | | | | | | | and manner as stated | | |
| HOSPITAL FUNERAL Within 72 | CO | | 96. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | | |
| THE DEED THE | O BE CO | | Stale | e.0 | in | \wedge | | | 29c. LICENSE NUM | G : | 29d. DATE | SIGNED (A | fonth, Day, Year) | | |
| 223 | 일 | - | O. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | | | , Print) | | 21021 | | 8 | -18 | 75 | | |
| 3) | | | Dr. Stephen P. | Staal | , 830 | | orpo | rat | te Dr. | Landove | r mo | 1 20 | 785 | | |
| | | 3 | 1. DATE FILEO (Month, Day, Year) | 12 REGISTRAN | SIGNATURE | 1.11 | | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

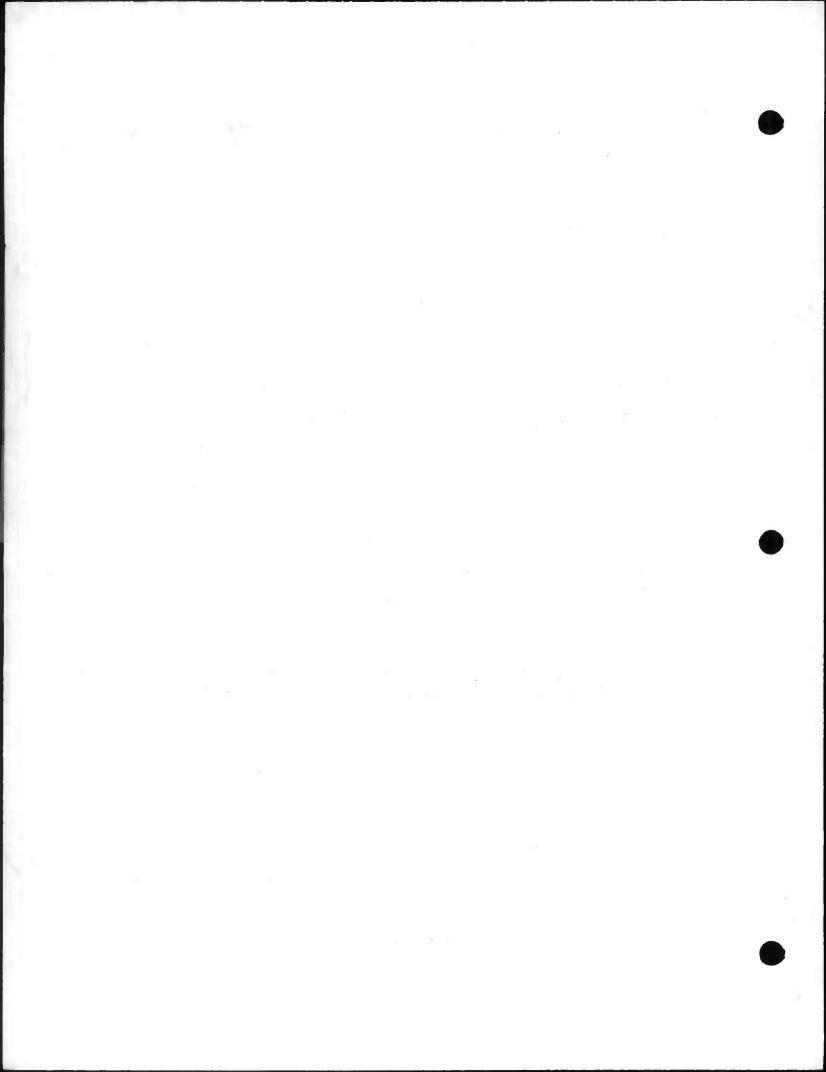
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | | | | | 10/111 | _ 01 | DEA | | HEG. NO |). | | | | | | | | | | | |
|----------------|-----------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------|-------------------|----------------------------------------------------------------------------------------------------|----------------|------------|--------------|-------------|----------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Mide SELL MAN | | ALVI | N | _ | | | | | 2. DATE OF DEATH | DAY | de 3 | TIME OF DEATH | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. I | asi birthday) | IF UNDER | R 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE OF BIRTH | 1 | -1- | ACE (State or Foreign | | | | | | | | | |
| | 220 34 85 | | 10 M 2 □ F | 56 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) | 39 | Mary1 | | | | | | | | | | |
| ~ | 99. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE | | | | | | | | | | | | | | | | | | | | | |
| 5 | Anne Arunde ¹ Medical Center Annapolis Finne Arund | | | | | | | | | | | Arunae | 1 | | | | | | | | | |
| [[| SAL OTATE SAL COMMEN | | | | | | | | | | | | | | | | | | | | | |
| DIRECTOR | Maryland Anne Arundel Lothian | | | | | | | | | | | | Od. INSIDE CITY LIMITS? YES 2 \(\text{NO} \) | | | | | | | | | |
| FUNERAL | 100. STREET AND NUMBER 1001. ZIP CODE 1009. CITIZEN OF 20711 U.S.A | | | | | | | | | | | | AT COUNTRY? | | | | | | | | | |
| Ä | | | | | | | | | 207 | 11 | | U.S.A. | | | | | | | | | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | | FORCES? 1 | | . ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Sp If yes, specify Cuban, Mexican, Puerto Rican, | | | | | IC ORIGIN? (Specify Yes, Puerto Rican, atc.) | s or No- | 14. RACE — Binck, Y | - American Indian, White, atc. | | | | | | | | | |
| BY | 3 Wildowed 4 Divorced | | IF YES, GIVE W | | | | | 2 (XNO | | | | Specify: | | | | | | | | | | |
| | 15. DECEDEN (Specify only high | | | 16a, D | ECEDENT'S | USUAL O | CCUPATIO | ON of world | 200 | 16b. KIND OF BU | SINESS/IN | DUSTRY | | | | | | | | | | |
| | Elementary/Secondary (0-12) | | College (1-4 or 5 + |) [| Give kind of a le. Do NOT us | | uuring mu | ASK OF WORKS | ng | | | | | | | | | | | | | |
| COMPLETED | 12th grade | | | | upervi | sor | | | | State Hig | ihway / | Adminis | tration | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, | | | | | | | 18. MOT | HER'S NAM | ME (First, Middle, Maider | | | | | | | | | | | | |
| BE | JOSEPI 19a. INFORMANT'S NAME (Type/P) | h Sellm | nan | | AL 884 H 104 | 100000 | | | | Florence Pr | | | | | | | | | | | | |
| 5 | Mrs. Mamie Sellma | | fe) | | 5097 E | d Pro | ut Ro | ad L | othia | n, Maryland | 2071 | p Code) | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 4 Donation 5 Other (Spec | | al from State | | CHIECE | | | ame of | Au | DATE 200. LC | SCATION - | city or Town | Maryland | | | | | | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SEP | RVICE LICEN | ISEE | , | | | | ND ADDRE | | Home, Inc. | | | | | | | | | | | | |
| | Jane Il | 1 | mode | isa | 1 | | | | | , N.E. Wash | ningtor | n, D.C. | 20019 | | | | | | | | | |
| | 23. PART I. Enter the disease shock, or heart | ses, or cor | mplications that | caused tha | laath. Do r | not antar | tha mo | da of dy | ing, such | as cardiac or reap | iratory ar | reat, | Approximate | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | rangre. Lie | it only one cau | se on each iir | 16. | | 1 | | | | | | Onset and Death | | | | | | | | | |
| | disease or condition resulting in death) | | 4 | udia | de | reit | | | | | | | 11. | | | | | | | | | |
| Ì | | | DUE TO | OR AS A CONS | EOUENCE OF | F): | 1 | - | | | | | - Cm | | | | | | | | | |
| N _C | Sequentially list conditions, | b., | 4 | many | ar | tery | y clicense | | | | | | 4 year | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | DUE TO | OR AS A CONSI | EOUENCE O | F): / | | | | | | | 20 m. | | | | | | | | | |
| 윤 | CAUSE (Disease or injury | C | DUE TO | ON AS A CONSI | EQUENCE OF | D. | | | | | | | 20 yrs. | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | | (| 1 | Lacence of | 1 | | 0 -1 | | | | | 1 | | | | | | | | | |
| 8 | | d | | mine | re | nal | -1 | Jana | ne | | | | 1 chr | | | | | | | | | |
| | PART II. Other significant co | onditiona | contributing to | death but not | resulting | n tha ur | darlyln | g cause | given in I | Part I. 24a. WAS AN | | | ERE AUTOPSY FINDINGS | | | | | | | | | |
| EDICAL | listet | U | | | | | | | | 1 TYES | | CC | MILABLE PRIOR TO OMPLETION OF CAUSE | | | | | | | | | |
| | | | | | | | | | | | | | F DEATH? | | | | | | | | | |
| ž | DID TOBACCO USE | CONTRI | BUTE TO CA | USE OF DEA | ATH YE | S 🗆 I | NO E | UNC | ERTAIN | 70 | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEI | DICAL | | | CE OF DEAT | | | | | | | | | | | | | | | | | |
| S | 1 YES 2 NO | | IOSPITAL: | ER/Outpatient | 3 DOA | OTHER 4 Nur | | io 5 □ Re | raidence I | 8 Other (Specify) | | | | | | | | | | | | |
| 호 | 27. MANNER OF DEATH | | 28a. DATE OF (Month, De | | 28b. TIM | E OF | 28c. INJ | URY AT | | 28d. DESCRIBE HOW | INJURY OC | CURED | | | | | | | | | | |
| BY F | 1 Natural 5 Pendi 2 Accident Invest | ing tigation | (MOTHIT, DA | iy. rear) | INJ | URY M | | PES 2 | NO | | | | | | | | | | | | | |
| | 3 Suicide 8 Could | | 28e. PLACE Of | FINJURY — A1 h | ome, farm, a | itree1, lect | ory, offic | • | | 281. LOCATION (Street | | r or Rural Roul | le Number, | | | | | | | | | |
| COMPLETED | | mined | bulluling, | ис. (эресну) | | | | | | City or Town, Stete |) | | | | | | | | | | | |
| <u> </u> | 29e. CERTIFIER (Check only | O PHYSICIA | N: To the best of | my knowledge, d | leath occurre | d at the t | lme, date | end place | , end due 1 | to the cause(e) end ma | nner as ata | fed. | | | | | | | | | | |
| S | | | | | | | | | | time, date end place, a | | | nd manner se stated. | | | | | | | | | |
| E C | 296. SIGNATURE AND TITLE OF | MATHER . | 1 | | | | | 29c. LICI | ENSE NUM | BER | 29d, DAT | E SIGNED /M | onth, Day, Year) | | | | | | | | | |
| 00 | larner 1 | Lun | lines | | | | | D: | 254 | 90 | • | 0/23/ | 95 | | | | | | | | | |
| 임 | 30. NAME AND ADDRESS OF PER | ISON/INFO C | COMPLETED CAUS | E OF DEATH (IT | EM 27) (Type, | Print) | | <i>D</i> 4 | -) (| 1. | | 8124 | 17 | | | | | | | | | |
| | 180 | Adm | iral 1 | Cochra | ine | Dy | | | Au | inapolis | m | 0 21 | 401 | | | | | | | | | |
| | | 995 | Jelia D | S SIGNATURE | reall | | | | | , | | 180 Admira Cochrane Du Annapolis MD 21401 31. DATE FILED (MONTH, Day, Year) 32. BEGISTRAR'S SIGNATURE AUG 24 1995 Jehin Developmentall | | | | | | | | | | |

| | | | DEPARTMENT OF HEA | ALTH AND MENTAL HYGIEN PEATH REG. NO. | | | | | |
|-----------------------------------------------------------------------------------------|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|--|--|--|
| | 100 | 1. DECEDENT'S NAME (First, Middle, Lest) HELEN L. SNOW | DEN | 2. DATE OF DEATH NONTH DA | YEAR 3. TIME OF DEATH A | | | | |
| 2/4 | | 4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 ☒ F 70 | " | F UNDER 24 HRS. 7. DATE OF BIRTH OURS MIN. JUNE 14, | 1925 Washington, D.C. | | | | |
| 2, 3 should | стоя | So. FACILITY NAME (If not institution, give street end number) SOUTHERN MARY MAND HOSPIT. RESIDENCE OF DECEDENT | 96. CITY, TOWN ORNE | OCATION OF DEATH | PAINCE CEOUS | | | | |
| 020 physician. burlat-transit permit. Pages 1. | DIREC | 10s. STATE 10b. COUNTY Maryland Prince George's | 10c. CITY, TOWN OR LOCATION Glendale | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | |
| sit permit | FUNERAL | 100. STREET AND NUMBER 11041 Brookland Rd. | | P CODE 0749 | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | |
| AND 21215-0020 the hospital or attending physician, detached for use as the burial-tran | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARIE FORCES? 1 YES 2 AN IF YES, GIVE WAR OR DATES | MED 13. WAS DECEND If yes, specific 1 Tyes 2 | DENT OF NISPANIC ORIGIN? (Specify Yes gruban, Mexican, Puerto Rican, etc.) NO Specify: | or No- 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 21215 oital or attend of for use as | COMPLETED | (Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4 or 5 +) | CEDENT'S USUAL OCCUPATION the kind of work done during most of Do NOT use retired.) | f working | SINESS/INDUSTRY Government | | | | |
| MARYLAND retained by the hospit 5 should be detached | COM | 17. FATHER'S NAME (First, Middle, List) | 10 | B. MOTHER'S NAME (First, Middle, Melden | | | | | |
| MARYL retained by 5 should be | | | b. MAILINO ADDRESS (Street and I | Henrietta Holt Number or Flural Route Number, City or Town | | | | | |
| By be rett | | | 913 Calvin St. | of DATE 200. LO | On, Md. 20744 CATION — City or Town, State | | | | |
| MOR ige 6 ma director, p | | 1 K Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | L'INCOLN° CEMETE | ERY 8/24 Bre | ntwood | | | | |
| BALTIMORE, after death. Page 6 may be by the funeral director, page moval. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSES. | M859 2617 | Penn. Ave., S.E. | , WDC 20020 | | | | |
| in the | | 23. PART I. Entar the diseases, or complications that caused the da shock, or heart failure. List only one cause on each line | ath. Do not enter the moda | of dying, such as cardiac or reapi | ratory arreat, Approximata interval Setween Onset and Death | | | | |
| P III III | | | | ascular occlus | | | | | |
| D 0 0 - 8 | | Constant No. | ongestive he | eart failure, | Days. | | | | |
| BOX ficate be physician ne prior b | | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | heric ischer | mic strokes | months. | | | | |
| Q 5 5 6 | CERTI | resulting in death) LAST d. Gangrene of right foot | | | | | | | |
| R at the and and and | ICAL . | recurrent gastrointestinal of gastric ulcer, renal fail | bleedings ar | nd history PERFOR | MED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| E 5 25 2 | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA | | | 1 YES 2 NO | | | | |
| | SICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Microsoft 1 Microsoft 2 PR/Outpetlent 3 | OTHER: | 5 Residence 6 Other (Specify) | | | | | |
| OF HYSIC his ce with th | | 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Dey, Year) 2 Accident Investigation | 28b. TIME OF 28c. INJURY WORK | Y AT N/A 2 NO NO N/A | NJURY OCCURED | | | | |
| DIVISION OR ATTENDING F DIRECTOR: After t hours after death | 8 | 3 Suicide 8 Could not be datermined 28a. PLACE OF INJURY — At he building, etc. (Specify) | ms, farm, street, factory, office N/A | 28t. LOCATION (Street a City or Town, State) | nd Number or Rural Route Number, | | | | |
| DI OR AL OR AL DIRI | COMPLET | 29a. CERTIFIER (Check only one) 1 V CERTIFYING PHYSICIAN: To the best of my knowledge, de LEAMINER: On the bests of examination and/or in the best of examination and/or in the best of examination and/or in the best of examination and/or in the best of examination and/or in the best of examination and/or in the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examination and the best of examinatio | | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 | BE | 296. SIGNATURE AND TITLE OF CERTIFIER PERFECT SU TIME IN SECTION | | D 12884 | 29d. DATE SIONED (Month, Dey, Year) Aug. 21 1995 | | | | |
| 7 | 10 | PETER W. YIM M.D. 7900 OLD B | | SUITE 101, CLI | NTON, MARYLAND 207 | | | | |
| (0) | | 31. DATE FILED (Month, Day, Year) 32. MEGISTRAR'S SIGNATURE | A at | • | | | | | |

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

| | 33 | | |
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| | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | | |
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| 300 | din. | | 167 |
| MIN. | unera | | and a |
| municipality after beath. Page o may be retained by the nospital of attending physician | the f | | is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| 2 | 70 | | 9 |
| 1 | pa d | 5 | Ĕ |
| P | ation | 500 | Ť. |
| IS A | . After this certificate has been signed by the attending physician and completely filled in by the formal with the Completely filled in by the formal with the Completely filled in by the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal states and the formal sta | 3 | rent |
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| De / | been | 5 | 2 |
| e law | has | 8 | 1 23 |
| IG PHYSICIAN: The law requires that the death certificate be executed with | cate | State | Hen |
| SE | ertifi | DIE. | 9 |
| HYS. | his c | M | ked, |
| NGF | fter t | MPS | шаг |
| END | or s | in or | |
| A | DIRECTO | S dil | n 28 |
| DR. | WL DIR | 100 | Te |
| PITA | ERAL | 7/ UI | DRTANT: If Item 28 |
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| 2 | 2 | 80 | E |

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|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------|-----------------------------------|--------------------------------------|---------------------------------|-----------------------------------------------------------------|-----------|--------------------------------------------|------------------------|---------------------------------|-------------------------------------------------------------------------|
| FOR 1 - STATE REGISTRAR | | STATE OF N | | | | F HEALTH AND | MENT | AL HYGIENI REG. NO. | | | |
| 1. DECEDENT'S NAME (Fir | B . | SE | RRI | 7 | | | 2. DAT | TE OF DEATH | 199 | 15 S | 350 A M |
| 4. SOCIAL SECURITY NUM 577-10-603 | | 5. SEX 1 M 2 F | 6. AGE (In yrs. 90 | | IF UNDER 1 YE | AR IF UNDER 24 HRS. | 7. DAT | il 13, 19 | 05 N | BIRTHPLAN Country) SW Jen | CE (State or Foreign |
| 9a. FACILITY NAME (If not MARINER H | EALTH | | | | | WN OR LOCATION OF O | EATH | | | OF DEATH | EORGES |
| nesidence of de | 10b. COUNTY | e George | es | | y, town on L 1ham | OCATION | | | | | . INSIDE CITY LIMITS? |
| 100. STREET AND NUMBE 9015 2nd | | | | - | | 101. ZIP CODE 20706 | | _ | 10g. CITIZE | N OF WHAT | COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Da | | 12. WAS OECEDEN FORCES? 1 IF YES, GIVE W | YES 2 | | If ye | DECENDENT OF HISPA a, specify Cuban, Maxic YES 2 NO Speci | en, Puerl | | | Specify: | Imerican Indian, lita, atc. |
| | ECEOENT'S EOUG only highest grade of (0-12) | | | Give kind of ville. Do NOT us BOOK I | vork done durir sa retired.) | PATION ng most of working | - 1 | Governm Offic | | | ng |
| 17. FATHER'S NAME (First, Arthur B. | | | | | | | | . Farbe | | | |
| 19a. INFORMANT'S NAME Robert L. | | | | | | reet and Number or Rural reet, Lanh | | | n, Stata, Zip C 706 | ode) | |
| 20a, METHOD OF DISPOS 1 N Buriel 2 Creme 4 Donation 8 Oth | er (Specify) | | 20b. PLA | or place) ngton Na | SITION (Name ational | of cometery, crometory or Cemetery | 8/2 | 3/95 Arl | ington, | | State |
| 21. SIGNATURE OF TUNE | SERVICE LICE | 1 K | who | | 22. NAI Rend 901.3 | on/Hale Fune Annapolis F | ral l | Home Lanham, | MD 207 | 706 | |
| 23. PART L Inter the mock, or iMMED ATK CAUSE (I disease of condition resulting in death) | heart fallure. L Final | Jat groty og o cau | on each | line. | 8 Car | a mode of dying, every deal | | | - | nt, | Approximata interval Between Onset and Death 5 min |
| Sequentially list conditions, leading to immodule. Enter UNDERI CAUSE (Disease or in that initiated events resulting in death) L/ | nediata LYING njury | | | NSEQUENCE OF | | | | | | | |
| PART II. Other aignifi | cant condition | contributing to | death but n | ot reaulting | in the unde | rlying cause given i | n Part I. | 24s. WAS AN PERFOR 1 YES 2 | MED? | CO OF | RE AUTOPSY FINDINGS INLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| 25. WAS CASE REFERRED | TO MEDICAL | 0.750 | | | | 26. PLACE OF DEATH (C | heck only | y one) | | | |
| EXAMINER? | | HOSPITAL: | ☐ ER/Outpation | mt 3 🗆 DOA | OTHER: | Home 5 Residence | 8 🗆 0 | Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Natural 8 [2 Accident | Pending Investigation | 28a. DATE Of (Month, L | | 28b. TIN | JURY | c. INJURY AT WORK? | 28d. | DEȘCRIBE HOW I | NJURY OCCL | RED | |
| • 🗆 • • • • • • • • • • • • • • • • • • | Could not be determined | 28e. PLACE (building | OF INJURY — / , atc. (Specify) | At home, farm, | atreet, factory | , office | | LOCATION (Street : City or Town, State) | | r Rural Routi | Number, |
| [Critical Orliny | | | | | | , data and place, and du slon, death occured at th | | | | | d manner as stated. |
| 29b. BIGHATURE AND TH | of al | / Lugh | | MD | | 29c. LICENSE NI | 9 4 | 12 | 29d. DATE | SIGNED (MG | onth, Day, Year) |
| 30. NAME AND ADDRESS | othy | 4 - (| DW1 | (ITEM 27) (Type | e, Print) | MD E | 33/ | 7 Cho | rry L | one | Laurofi |
| 31. DATE FILED (Month, D | 2 1995 | 32. REGISTR | AR'S SIGNATU | ardall | | | | | , | | 2070 |

DHMH-18 Rev 1/89

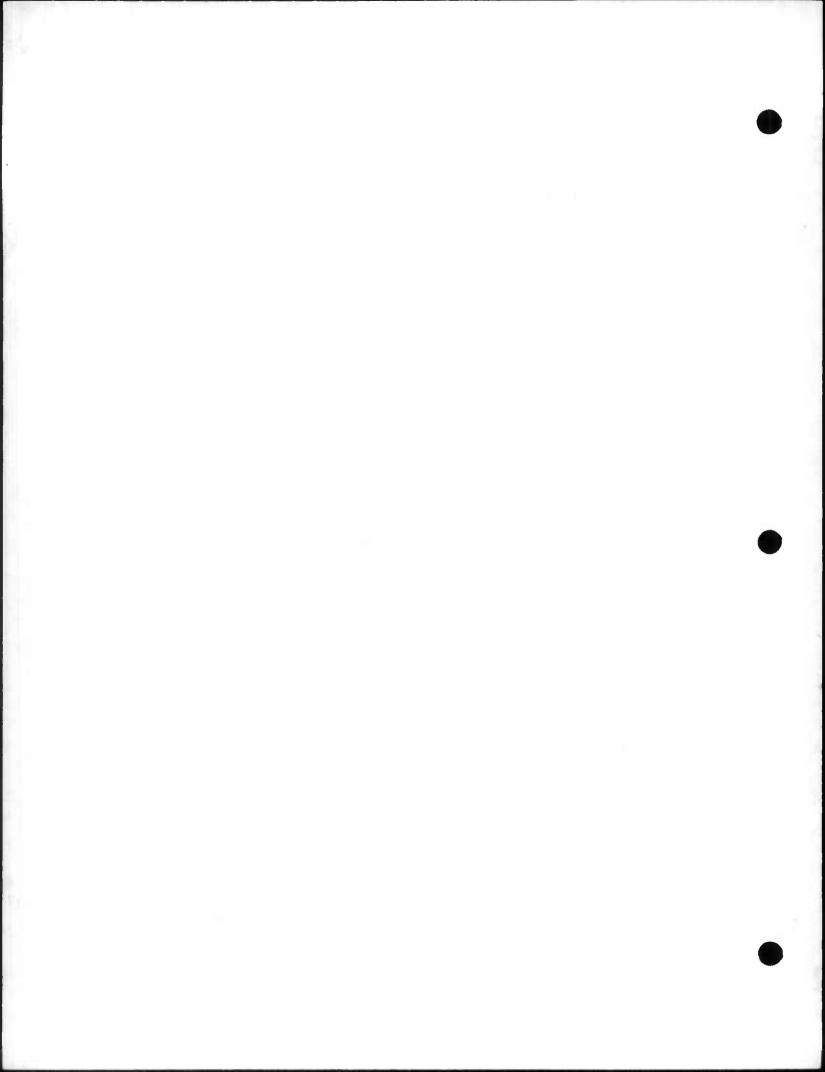
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE OF MARYLAND / DEPARTMENT OF H | | HYGIENE REG. NO. | |
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| 1. DECEDENT'S NAME (First, Middle, Leal) | 2. DATE (| OF DEATH | 3. TIME OF DEATN |
| MELVIN L. SKINNER | MONTH | ust 11 19 | 95 12:20 a M |
| 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE O | OF BIRTN A | BIRTNPLACE (State or Foreign |
| 578-70-2442 1 M 2 F 42 YRS. MONTHS DAYS | | Dey, Year) th 19, 1953 | Statesville, N.C. |
| | OR LOCATION OF DEATH | 9c, COUNTY | |
| Hyattsville Health Care Center RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY District of Columbia | yattsville | Prim | nce George's |
| 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCAT | ION | | 10d. INSIDE CITY |
| District of Columbia | Washington | | LIMITS? |
| I 100. STREET AND NUMBER | ZIP CODE | 10g. CITIZEI | N OF WHAT COUNTRY? |
| 535 - 51st Street, N.E. | 20019 | Uni | ited States |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DEC | ENDENT OF HISPANIC ORIGIN? | ? (Specify Yee or No- 14 | . RACE — American Indian. |
| | ecify Cuben, Maxican, Puerto Ri 2 X NO Specify: | icen, etc.) | Black, White, etc. Specify: |
| a la monte | 14 | | Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 th 17. FATNER'S NAME (First, Middle, Last) 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during mo life. Do NOT use retired.) Laborer Laborer | ON 16b. | KIND OF BUSINESS/INDUS | TRY |
| Elementary/Secondary (0-12) College (1-4 or 6+) Iffe. Do NOT use retired.) | | | |
| 12th Laborer | | Govern | nment |
| 17. FATNER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, M. | liddle, Malden Surneme) | |
| Donald Skinner | | Joyce Brown | |
| O 198. INFORMANT S NAME (1/PPN/PTIR) 198. MAILING ADDRESS (Street e | | | |
| Joyce L. Skinner 535 - 51 | st Street, N. | .E. Wash., | D.C. 20019 |
| 20s. METHOD OF DISPOSITION 1 XBurlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (No | me of OATE | 20c. LOCATION - City | y or Town, State |
| 1 XBurlei 2 Cremetion 3 Removal from State Comptery, cremetory or other place) Camptery, cremetory or other place) Harmony Memorial | Park 8/15/9. | 5 Lando | ver, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AN | D ADDRESS OF FACILITY | Stewart Fur | |
| Short Hum T TT 4001 | | Stewart rui | neral nome |
| 7 (1) | D D -1 | NT 19 171- | D C 20010 |
| 4001 | | | ., D.C. 20019 |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the moshock, Dr heart failure. List Dnly ona cause on each lina. | | | |
| 23. PARTILENter the disease, or complications that caused the death. Do not enter the most ahock, or heart failure. List only one cause on each line. IMMEDIATE GAUSE (Finel | de of dying, such as cardi | | Approximete |
| 23. PART Lenter the disease, or complications that caused the death. Do not enter the most about, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition Acquired Immune Deficiency as a condition or resulting in death) | de of dying, such as cardi | | Approximete interval Between |
| 23. PART L.Enter the diseases, or complications that caused the death. Do not enter the most about, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition) Acquired Transport Deficiency | de of dying, such as cardi | | Approximete interval Between |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the most abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Acquired Immune Deficiency Due to (or as a consequence of): | de of dying, such as cardi | | Approximete interval Between |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the most abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Acquired Immune Deficiency Due to (or as a consequence of): | de of dying, such as cardi | | Approximete interval Between |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the most abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Acquired Immune Deficiency Due to (or as a consequence of): | de of dying, such as cardi | | Approximete interval Between |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the most abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Acquired Immune Deficiency Due to (or as a consequence of): | de of dying, such as cardi | | Approximete interval Between |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the most abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Acquired Immune Deficiency Due to (or as a consequence of): | de of dying, such as cardi | | Approximete interval Between |
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| 23. PARTY LEnter the diseases, or complicatione that caused the death. Do not enter the moshock, or heart failure. List only ona cause on each lina. IMMEDIATE CAUSE (Finel disease or endition resulting in death) ACQUITED Immune Deficiency DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A | Snydrome Snydrome Cause given in Part I. UNCERTAIN TO S Rasidence 6 Other JRY AT 28d. DESC 28d. DESC City or and place, and due to the cause seth occurs at the time, date at 29c. LICENSE NUMBER 29c. LICENSE NUMBER | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO (Specify) THON (Street and Number or 17 Nown, Stele) be(e) end manner as stated. and place, and due to the cu | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

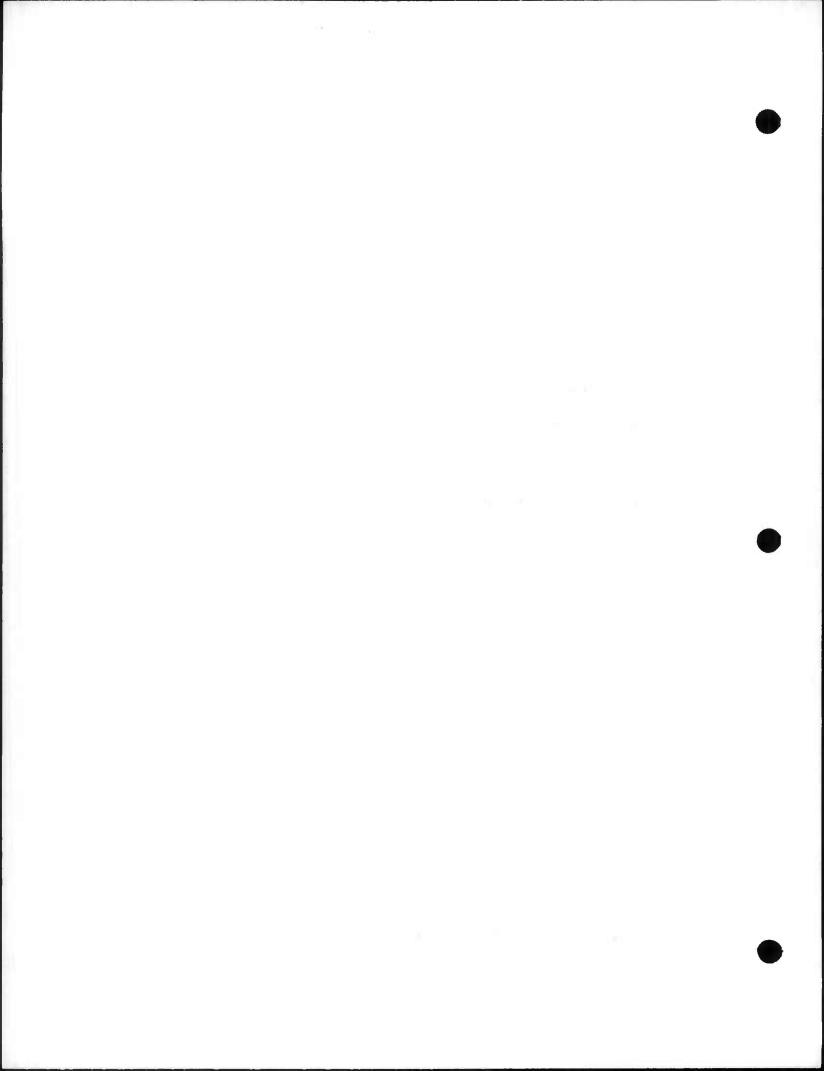
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

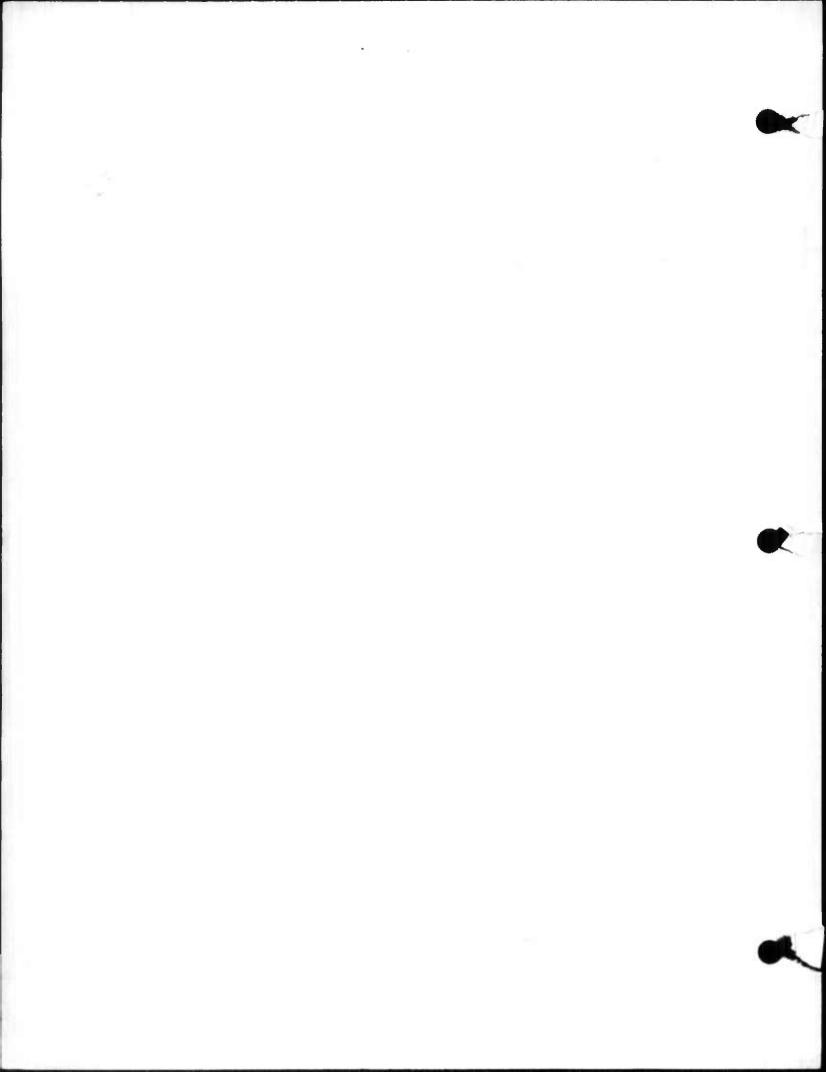
| | 1 - STATE REGISTRAR CERT | TIFICATE | OF DEAT | LH ME | REG. NO. | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------|----------------|-----------------------------------------------|----------------|--------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | - | 2 | P. DATE OF DEATH | | YEAR | 3. TIME OF DEATH |
| | NANETTE LEE STANLEY | | | 1 | AUG. 22 | 199 | | 4:25 AM " |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birth | | | 24 HRS. 7 | DATE OF BIRTH (Month, Day, Year) | | | PLACE (State or Foreign |
| | 037 ZZ Z713 - X 07 | RS. MONTHS | DAYS HOURS | MIN. | FEB.1, 1 | 928 | NEW | YORK |
| | Sa. FACILITY NAME (If not institution, give street and number) | 9b. CITY, | TOWN OR LOCATION | | | | NTY OF DE | EATH |
| OR | 212 S. MORRIS ST. | OX | FORD | | | | TAT. | вот |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10a | | | | | | | DOI |
| 2 | | c. CITY, TOWN OF | | | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND TALBOT | OXFO | _ | | | | | 1 X YES 2 NO |
| RA | | | 101. ZIP CODI | | | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| FUNERAL | 212 S. MORRIS STREET 11. MARITAL STATUS 12. WAS DECEMENT EVER IN U.S. ADMED. | | | 21654 | | <u> </u> | | USA |
| | 11. MARITAL STATUS 1 Nover Married 2 Married 12. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO #FYES, GIVE WAR OR DATES | ll ll | yes, specify Cuba | n, Mexican, F | ORIGIN? (Specify Yes Puerto Rican, etc.) | or No- | 14. RACE Black, | — American Indian, White, atc. |
| ВУ | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES | 1 | YES 2 XNO | Specify: | | - 1 | Specifi | WHITE |
| Q | 15. DECEDENT'S EDUCATION 16e. DECEDE | ENT'S USUAL OC | CUPATION | | 16b, KIND OF BUS | INE CO /IND | HETOV | MILLE |
| ETE | (Specify only highest grade completed) (Give kin | nd of work done di VOT use retired.) | iring most of working | g | IGU, KIND OF BUS | ME 33/IND | USTAT | |
| PL | | TOUR | DEALER | | DEM | AIL | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | LIQUI | | ER'S NAME | (First, Middle, Malden | | | |
| | MATTHEW MERRILL GRODNICK | | | LEN | BERTHA | | ERM | Отт |
|) BE | SAMP NEW YORK | ILING ADDRESS | | | te Number, City or Town | | | 011 |
| 5 | | | | | OXFORD, | | | 5.4 |
| | 20a, METHOD OF DISPOSITION | ATE OF DISPOSIT | | | | CATION — | | |
| | 1 Burtal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SALISBU | JRY CR | EMATORY | 7 8 | 3-25 SAL | TSRI | IDV | MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. N | AME AND ADDRES | S OF FACILI | TY | | | 110 |
| | ·M. E. Dee man GFS | S.A NI | EWNAM I | UNER | RAL HOME | , P. | Α. | |
| | 23. PART I. Enter the diseases, or complications that caused the death. | 1 24 | JU 13 1 | | *3/ 1/A *3 * | | 1.7 | Approximats |
| | snock, or neart failure. List only one cause on each iina. | · · · · · · · · · · · · · · · · · · | ila ilioua oi uyi | ng, sacir s | a cardiac or respi | atory arr | wat, | Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | BLEN | TON | 2000 | 21/4- | | | Onset and Death |
| | resulting in death) S DUE TO (OR AS A CONSEQUENCE) | | Carle | CINC | JAN | | | 13 years |
| _ | | 02 01 /. | | | | | | |
| 9 | Sequentially flat conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE) | CE OF): | | | | | | |
| 3 | cause. Enter UNDERLYING | | | | | | | |
| Ĕ | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE | CE OF): | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | |
| | PART ii. Other algnificant conditions contributing to death but not result | ting in the und | arlying series o | duen in Dec | a (| Attrangu | Lan | |
| DICAL | | any in the diff | arrymig causa g | iveii iii rai | PERFOR | MEDP | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| | | | | | 1 TYES 2 | NO | | OF DEATH? |
| Σ | DID TORACCO LISE CONTRIBUTE TO CALICE OF DEATH | VEC 🗆 N | A | FDTAIL | - | | | 1 TYES 2 NO |
| PHYSICIAN: ME | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF | YES N | | ERTAIN | | | | |
| 泛 | EXAMINER? HOSPITAL: | OTHER: | ./ | | | | | |
| ΗŽ | | | eg Home 5 Re: | | Other (Specify) | 1 d 1 m/ 0 0 0 | | |
| | 1 Netural 5 Pending (Month, Day, Year) | INJURY | WORK? | | id. DEŞCRIBE HOW IN | IJUHY OCC | URED | |
| B | 2/ Accident Investigation 3 Suicide 5 Could not be 26a. PLACE OF INJURY — At home, to | arm street feeter | | | 1.00471011 (2) | | | |
| | 4 Homicide determined building, atc. (Specify) | erin, acreer, ractor | y, ornes | 20 | R. LOCATION (Street a City or Town, State) | nd Number | or Hural Ric | oute Number, |
| COMPLET | 29e. CERTIFIER | | | | | | | |
| MP | (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death oc | | | | | | | |
| 8 | MEDICAL EXAMINER: On the basis of examination and/or investig | Igation, in my opi | nion, death occur | ed at the time | e, data and place, and | f due to the | o cause(a) | and manner so stated. |
| BE | 296. SIGNATURE AND TITLE OF CHITISTER | | 29c. LICE | NSE NUMBER | R | 29d. DATE | SIGNED (| Month, Day, Year) |
| 2 | DE NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH LITEM TO | | | SZ | 59 | ▶ 8 | 470 | ZM5 |
| - 1 | 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH STEM 377 | Zon Print | Vo. Z | 11-2 | | | | |
| Į, | AL DATE EN ED (Month Day Mari) | 1001 | ביוט | 100 | / | | | |
| | 31. DATE FARD (1002) 37 1995 July David World | | | | | | | |
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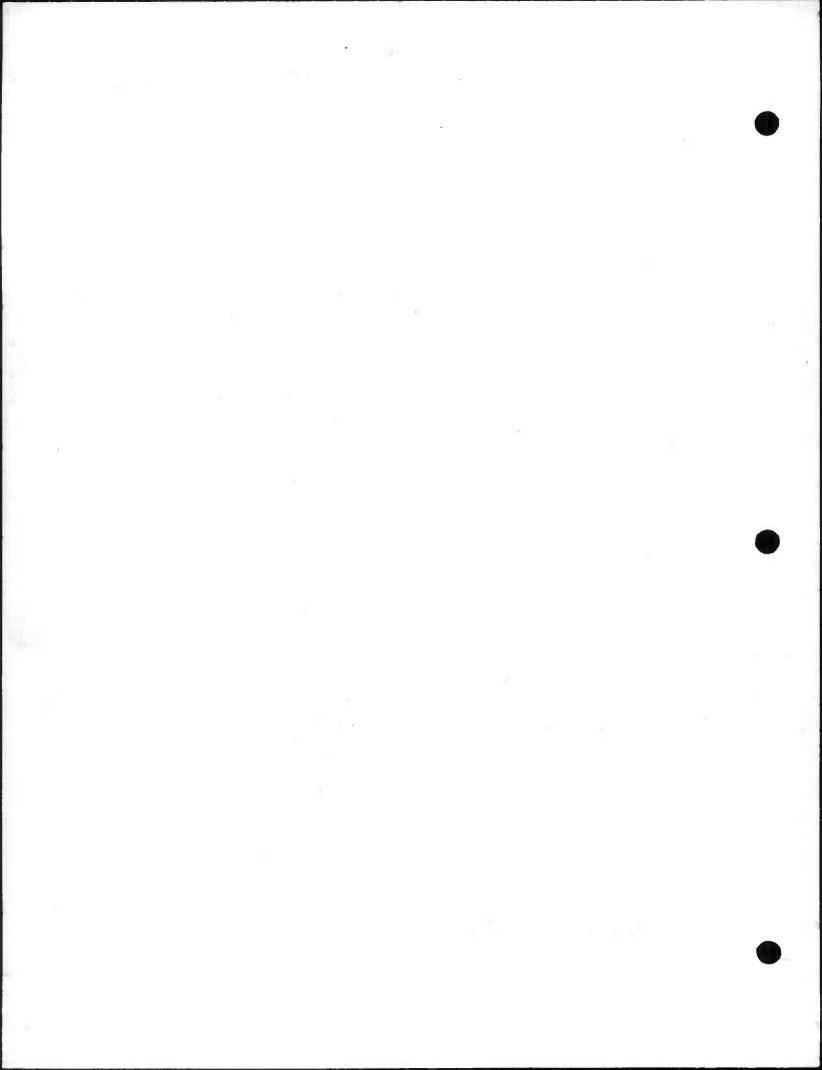
| + + > E | # # # E | | HOSPITY TUNERA VITHIN 7. | L OR ATTEN L DIRECTOR: hours after I Item 28 I | DING deat deat | r this c th with arked, | ICIAN entific the | Cate | law Dept. 23 | een sig of He: | ned t | t the d by the nd Mer | attend tal H | fing ph ygiene othe | ate by hysicia prior | n and to bur | comple fal, crei | tely fi mation | hound led in 1, or r | by the | death. | Page al direc | 6 may ctor, p | de 5 age 5 | should | at o d | e hosp etache | pita p |
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RAL DIRECTOR: After this certificate has been signed by the attending physician and n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bur It Rem 28 is marked, or Item 23 shows any Injury, or either traumatic. | 917AL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed wit RAL DIRECTOR: After this certificate has been signed by the attending physician and comple not 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crest: If Item 28 is marked, or Item 23 shows any injury, or other traumatic even | PITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within a RAL DIRECTOR: After this certificate has been signed by the attending physician and completely find 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, this | PITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours. RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ri. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the med | 917AL OR ATTENDING PHYSICIAN. 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The law requires that the death certificate be executed within 25 frouts after death. Page RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 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Page 6 may RAL DIRECTOR: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, p n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. It from 28 is marked, or filem 23 shows any injury, or other traumatic event, the medical examiner must | PITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within the hours after death. Page 6 may be re RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. It flem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be no | PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained FRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be d a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. It kem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at o | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 75 hours after death. Page 6 may be retained by the hospital TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached it be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. |
|-------------------------------------|------------------------------------------------|----------------------------|
| CEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH |

| | REGISTRAR | | CERTIFI | CATE C | F DEATH | B | EG. NO. | | | |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------|------------------|----------------------------------------------|------------------------------|------------------------------------|-----------------|------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF D | | | 3. TIME OF DEATN | |
| | HERCULES | DORN | Stewa | art, | JR. | July | 22 19 | 95" | 11:36A M | |
| | 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEA | | 7. DATE OF B | IRTN Vanc) | 8. BIRTH | PLACE (State or Foreign | |
| | 200-26-8079 | | 62 YRS. | MONTHS DAT | NOUNE MINE. | AUG. 2 | 0,1932 | PEN | NSYLVANIA | |
| _ | 9a. FACILITY NAME (If not institution, give str | reet and number) | | 9b. CITY, TOY | VN OR LOCATION OF DE | EATH | 9c. COU | NTY OF D | ATN | |
| DIRECTOR | MEMORIAL HOSPI | TAL | | EA | STON | | 7 | CALB | TO | |
| 딦 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10e, CITY | TOWN OR LO | CATION | | | | 10d. INSIDE CITY | |
| 뜻 | MARYLAND T | ALBOT | | XFORE | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | швот | 0. | AF OIL | 101. ZIP CODE | | 10a CIT | IZEN OF W | HAT COUNTRY? | |
| FUNERAL | 4330 WORLD FAR | M ROAD | | | 216 | 54 | 100.00 | US | | |
| Š I | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS | DECENDENT OF NISPAI | | ecity Yes or No | | American Indian, | |
| BY F | 1 Never Married 2 Married 3 Never Married 2 Neverted | FORCES? 1 X YES IF YES, GIVE WAR OR DA KOREA | 2 NO ATES | If yes | , specify Cuban, Maxica YES 2 X NO Specif | n, Puerto Rican | , etc.) | Black Specif | White, etc. | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | | 16a. DECEDENT'S U (Give kind of wo | ork done during | ATION most of working | 16b. KJN | D OF BUSINESS/IN | DUSTRY | | |
| ۳ ا | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT use | retired.) | 2 | | | | | |
| ₹ E | 12 | 4 | EXECU | TIVE | | | | MA | NUFACTURIN | |
| 3 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | , Maiden Surname) | | | |
| H | HERCULES DORN | STEWART | | | | | OUGHRII | | | |
| 2 | 19s. INFORMANT'S NAME (Type/Print) | | 1 | | et and Number or Rural | | | | | |
| - | JUDY STEWART | | | | D FARM F | 7 | | | | |
| | 20e, METHOD OF DISPOSITION 1 | | PLACE AND DATE OF | | | 7-24 | SALISBU | | | |
| į | 21. SIGNATURE OF FUNERAL SERVICE LICE | | 0 | N F.W | AND ADDRESS OF FA | CILITY PAT. H | OME D | Δ | | |
| | > 14 to Neu | Mari | FSP. | 200 | S. HARF | RISON | ST., E | ASTO | N, MD | |
| RTIFICATION | snock, or heart feilure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | | : | F Info | ne Fee | 2 | | Interval Between Onset and Death Musukes | |
| Ē | resulting in death) LAST | | | | | | | | | |
| S | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS | | | | | | | | | |
| DICAL | 7/ agrifficant conditions | contributing to deeth be | ut not reaulting in | the underly | ying cause given in | Part I. 24e. | WAS AN AUTOPSY PERFORMED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| וַ הַּ | - Hyper year | con | | | | | YES 2 NO | OF DEATH? | | |
| Σ | DID TODACCO HEE CONTR | ADDITE TO CALICE O | | | | 34 | | | 1 TES 2 NO | |
| 2 | DID TOBACCO USE CONTR | | | | | NKI | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? EXAMINER? CONTROL CO | | | | | | | | | |
| ׅ֓֟֟֝֟֝֟֟ | 1 YES 2 NO 27. MANNER OF DEATN | 1 Inpatient 2 ER/Outpo | atlent 3 PQ DOA 2 | | tome 5 Residence | | | | | |
| 87 2 | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJU | RY | INJURY AT WORK? YES 2 NO | 28d. DESCHIB | E NOW INJURY OC | CURED | | |
| 3 | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY building, atc. (Speci | At home, farm, str ify) | reet, factory, c | offica | 28f. LOCATION City or Tox | N (Street and Number vn, State) | r or Rural A | oute Number, | |
| COMPLE | 290. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my knowle | edge death conver | at the time | late and place and a | to the entire of | | | | |
| <u> </u> | (Crieck only | R: On the besis of examination | | | | | | | and manner or stated | |
| - 111 | 296. SIGNATURE AND TITLE OF CERTIFIER | | | , | | | | | | |
| | STATE OF CERTIFIER | 2000 | DA | | 29c. LICENSE NUI | 1574 | | -22- | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATN (ITEM 27) (T=) | Print) | 0 3/5 | , , , | | - 44 | 75 | |
| | GROVER DAVIS, | | | | AT PACE | TEO! | D 21601 | | | |
| | 31. DATE FILED (Month, Day, Year) | | | OSPIT | AL, EAST | UN, M | D 51001 | | | |
| | JUL 24 1995 | REGISTRAR'S SIGNA | Kardall | | | | | 4 | | |
| | | | | | | | | | | |



| | | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | IEALTH AND I | MENTAL HYGIE | | |
|--------------------------------------------|----------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------|---------------------|------------------------------------|----------------------------------------------|---------------------|-----------------------------------------------------------------|
| | | | 1. OECEOENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | DAY YE | 3. TIME OF DEATN |
| | | | | Beatrice Sidn | ey | | | July 17, | 1995 YE | 6:00 a |
| | | | 4. SOCIAL SECURITY NUMBER 216-40-4607 | 5. SEX 6. AGE (I | | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) June 15, | | BIRTHPLACE (State or Foreign Jountry) |
| | should | | 9e. FACILITY NAME (If not institution, give | street and number) | | b. CITY, TOWN (| OR LOCATION OF DE | | 9c. COUNTY | |
| | 1, 2, 3 s | CTOR | Corsica Hills N | ursing Center | | Centre | eville | | | n Annes |
| | | DIREC | 10e. STATE 10b. COUNT | | | TOWN OR LOCAT | | | | 10d, INSIDE CITY LIMITS? |
| | permit. Pages | AL D | Maryland Que | en Annes | Cen | trevil | LE CODE | | 10g. CITIZEN | 1 VES 2 NO |
| au. | | I III | P.O. Box 173 | | | | 21617 | | USA | |
| | the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Merried 2XXMerried 3 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 XNO | If yes, sp | ecify Cuben, Mexican 2 ANO Specify | | pe or No— 14. 1 | RACE — American Indian, Black, White, etc. Specify: Black |
| 21 age = 21 | use as | ETED | 15. DECEOENT'S EOU (Specify only highest grade | JCATION completed) | 16a. OECEOENT'S US (Give kind of wor | k done durina ma | ON st of working | 16b. KINO OF BI | USINESS/INDUST | RY |
| ND 27 | shed for | COMPLE | Elementary/Secondary (0-12) 7th | College (1-4 or 5+) | Domesti | | | Home H | Engineer | ing |
| A B | be detached at once. | - 1 | 17. FATHER'S NAME (First, Middle, Last) William Cuff | | | | | ME (First, Middle, Meide Brooks | n Sumeme) | |
| MARY retained by | - | 띪 | 19e. INFORMANT'S NAME (Type/Print) | | 195 MAILING AL | ODESS /Street s | | loute Number, City or To | | |
| | 5 should notified | 일 | Linda Hynson | | | | | Easton, N | | |
| May be | page : | | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rem | 20b. | PLACE AND DATE OF | DISPOSITION (Na | ame of | | OCATION — City | |
| Page 6 | director, p | | 4 Donation 5 Other (Specify) | | ctery crematory of other nesterfie | Td Cem | etery | 7-22-92 | Centrev | ville, Md. |
| eath. P | funeral | | 21. SIGNATURE OF TUNERAL BERVICE LI | D Aga C Q) | | | | Funeral 37, Eastor | | |
| The sunot #2 | ompletely filled in by the il, cremation, or removal. event, the medical ex | | 23. PAIT Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | complications that ceused List only one cause on es | ich line. | enter the mo | de of dying, auch | as cardiac or reap | piratory arrest, | Approximate Interval Between |
| P.O. BOX be ath certificate be execu | ending physician and corr I Hygiene prior to burial, or other traumatic ex | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C. | CONSEQUENCE OF): | Me | etyn | DIB B AMBA | | |
| ž č | by the att and Menta ry Injury, | AL. | PART II. Other aignificant condition | ns contributing to deeth bu | ut not resulting in | the underlying | g cause givan in I | | N AUTOPSY PRMEO? | 24b. WERE AUTOPSY FINDING |
| 5 £ | 2 E g | MEDIC | | | | | | 1 YES | NO NO | OF DEATH? |
| Tequi | 5 6 G | Σ | DID TOBACCO USE CONT | DIDLITE TO CALISE OF | E DEATH VEC | | (III I CERTAIN | | | 1 TYES 2 NO |
| A L | N Deg | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | 6. PLACE OF DEATH | | UNCERIAIN | | | |
| | certificate h h the State d, or Item | Sic | EXAMINER? | HOSPITAL: 1 Inputient 2 ER/Output | _ 0 | THER: | e 5 🗆 Reeldence (| Other (Specific | | |
| NSICI/ | this certil with the ked, or | РНҮ | 27. MANNER OF OEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | F 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCCURE | D |
| 4G PH | | BY | 1 Netural 5 Pending 2 Accident Investigation | | | M 1 1 | ES 2 NO | | | |
| ATTENDING PHYSICIAN: The law requires that | after d | G | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, atc. (Speci | — At home, ferm, stre | et, factory, office | • | 281. LOCATION (Street City or Town, State | | ral Route Number, |
| 5 8 | AL DIREC | PLET | 290. CERTIFIER Check only | ICIAN: To the beat of my knowle | edge, death occurred | it the time, date | end place, end due t | to the cause(e) end ma | inner ee stated, | |
| SPITE | CC | COMP | | R: On the beele of exemination | | | | | | se(e) end manner ee atated. |
| 署 | TO THE FUNE be filed within IMPORTANT | BE | 296. SIGNATURE AND TITLETOF CERTIFICA | mek. | mil | | 29c. LICENSE NUM | 548 | 29d. DATE SIG | NED Month, Day, Year) |
| | | 2 | Eric F. Ciganek, | · · | | | | : | | |
| | Ì | | 31. DATE FILED (MONT), DON'T SAN 1995 | MD P.O. Bo | OK 339, C | entrevi | lle, Md, | 21617 | | |



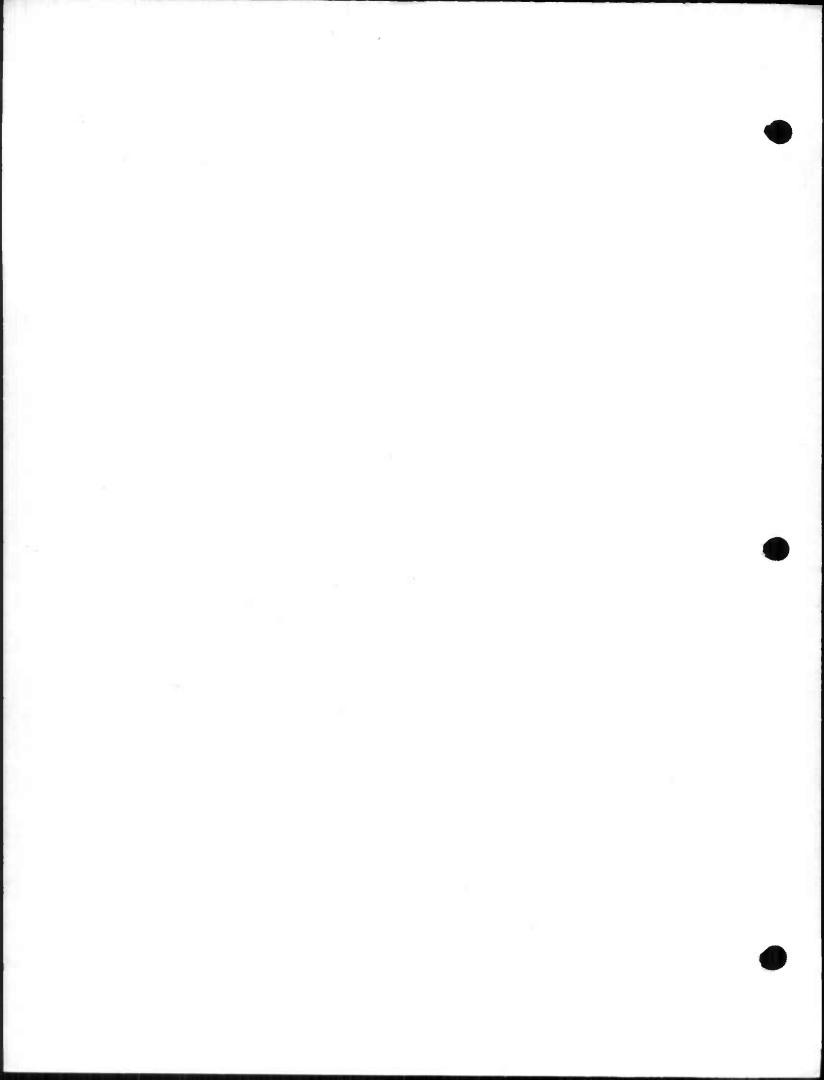
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DHECKIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MENDIFFARE IF them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

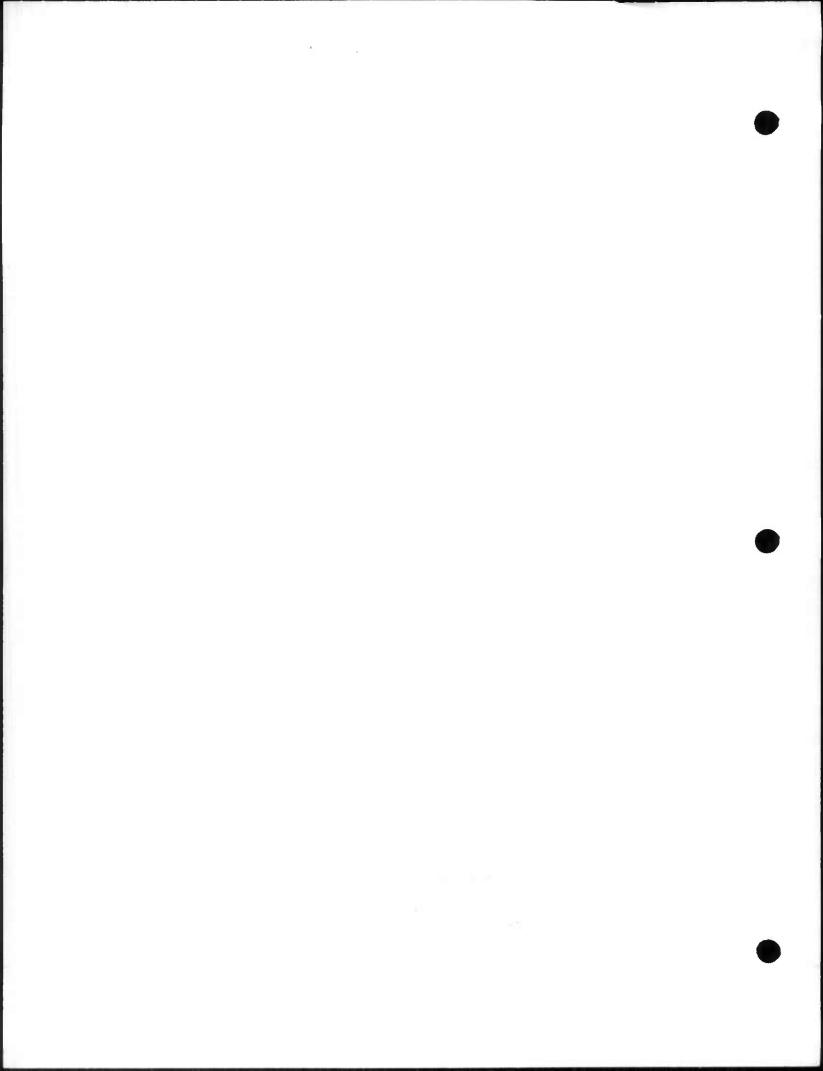
TO BE COMPLETED BY FUNERAL DIRECTOR

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | | | | | MENTAL | HYGIENI REG. NO. | E | | |
|----------------|-----------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------|------------------------|----------------------|---------------|-------------------|-----------------------|------------------------------|-------------|-------------------|----------------------------------------------|
| | DECEDENT'S NAME (First, Middle, Last) | | OLITTI | IOAII | | lor los r's i | | 2. DATE O | E DEATH | | | 3. TIME OF DEATH |
| | Bertha Mae Smit | th | | | | | | Augus | st 18 | 8, 19 | 95 | 9155 N |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE O | F BIRTH | , | 6. BIRTHP | LACE (State or Foreign |
| | 217-30-9112 | 1 M 2 X F | 60 YRS. | MONTHS | DAYS | HOURS | MIN. | May | Day, Year) 17,193 | 3.5 | Mar | yland |
| | 9e. FACILITY NAME (If not institution, give stre | eet and number) | | 9b. CITY | r. TOWN O | R LOCATI | ON OF D | | 1,11 | | NTY OF DE | |
| œ | 504 West Vaughn | | | | ceens | _ | | | | | olin | |
| DIRECTOR | RESIDENCE OF DECEDENT | Jileet | | 01 | Cens | DOLC | | | | Var | OTTI | - |
| E I | 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| 2 | Maryland Care | oline | Gı | ceens | sbord |) | | | | | | 1 F YES 2 NO |
| | 10e. STREET AND NUMBER | | | | 101. | ZIP CODI | E | | | 10g. CIT | ZEN OF W | HAT COUNTRY? |
| ER/ | 304 West Vaughn | Street | | | | 2163 | 39 | | | Į | JSA | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | | | | NIC ORIGIN? | | or No- | 14. RACE | - American Indian, |
| BY FI | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES | | | If yes, spe 1 TES | | n, Mexic Speci | an, Puerto Ri lly: | cen, etc.) | | Black, Specify | Black |
| | 15, DECEDENT'S EDUC | ATION | 16e. DECEDENT'S | USUAL C | CCUPATIO | N N | | 16b. I | KIND OF BUS | INESS/INI | DUSTRY | |
| COMPLETED | (Specify only highest grade of | | (Give kind of life. Do NOT u | work done se retired.) | during mo: | st of working | ng | 100 | | | | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Labor | rer | | | | | Factor | CV | | |
| MO | 17. FATHER'S NAME (First, Middle, Lest) | | | | | ts. MOT | HER'S N | AME (First, Mi | | | | |
| | Barney Hutchins | | | | | 7 | /iol | a Gre | en | | | |
| B | 19a, INFORMANT'S NAME (Type/Print) | | 19b. MAILING | 3 ADDRES | S (Street e | nd Numbe | or Rumi | Route Numbe | r City or Towi | n State Zi | o Code! | |
| 2 | Lloyd Smith | | | | | | | | | | | . 21639 |
| | 200. METHOD OF DISPOSITION | 20 | b. PLACE AND DATE | | ** | | | DATE | | | City or Toy | |
| | 1 X Buriel 2 Cremation 3 Remo | | John Wes | | | | rch | 1 | 4/95 | | | el, Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE | | oom web | | | | | | | | | |
| | 1 | | | | | | | h Fun | | | | |
| | | | | | P.0. | . Box | k 16 | 87, E | aston | , Md | . 216 | 01 |
| | 23. PART I. Enter the diseases, or co shock, or heert fellure. L IMMEDIATE CAUSE (Fins) | | | not ente | r the mo | de of dy | ing, au | ch aa cardi | ac or respi | ratory ar | rest, | Approximate interval Between Onset and Death |
| | disease or condition | | (K101 11. | 04 | 10 | | | | | | | 1-7 abo. |
| | resulting in death) a | DUE TO (OR AS | A CONSEQUENCE O | OF): | -4 | | | | | | | . 0 64 4 |
| - | | | Parox | 200 | in | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE | F): (| 8 | | | litic | | | | |
| ES | cause. Enter UNDERLYING | | Crau | ove | Jse | w | کەم | lite | i. | | | |
| Ĕ | CAUSE (Disease or Injury that initieted events | DUE TO (OR AS | A CONSEQUENCE O | OF): | | (| 7 | | | | | |
| H | resulting in deeth) LAST | | | | | | | | | | | |
| | DART II Out as already and distance | | had a set as a data | 1- 41- | -4 -4 -4 | | | - Down I | | | | |
| CAL | PART II. Other significant conditions | contributing to deeth | out not resulting | in the u | noeriying | g cause | given ii | n Part I. | 24s. WAS AN PERFOR | | 240. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| - | | | | | | | | | 1 YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | | 1 TES 2 NO |
| PHYSICIAN: MED | DID TOBACCO USE CONTR | IBUTE TO CAUSE | OF DEATH Y | ES 🗆 | NO X | UNC | ERTA | IN 🗆 | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER'S | HOSPITAL: | 26. PLACE OF DE | | | | | | | | | |
| SI | 1 TES 2 NO | 1 - Inpatient 2 - ER/Ou | ripatient 3 🗆 DOA | 4 A Nu | irsing Hom | 6 5 A | esidence | 6 C Other | (Specify) | | | |
| Hd | 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | | ME OF | 28c. INJ WO | URY AT | | 28d. DE\$6 | CRIBE HOW I | NJURY O | CCURED | |
| ВУ | Netural 5 Pending 2 Accident Investigation | | | M | 1 🗆 ' | YES 2 [| NO | | | | | |
| ED E | 3 Suicide 8 Could not be | 26e. PLACE OF INJUF building, etc. (Sp | | street, fee | ctory, offic | 0 | | | TION (Street or Town, State) | | er or Rumi A | outs Number, |
| 1 | 4 Homicide determined | | | | | | | | | | | |
| COMPLET | 29a. CERTIFIER CERTIFYING PHYSIC | CIAN: To the best of my kno | wledge, death occur | red at the | time, date | and place | e, and du | ue to the ceu | se(e) end mai | nner es ste | sted. | |
| W . | one) | R: On the besis of examinat | ion and/or investigat | lon, In my | opinion, d | leath occu | red at th | ne time, date | end place, an | nd due to t | the ceuse(e) | end manner ee stated. |
| | 290 SUMATURE AND TITLE OF CERTIFIER | 1 | | | | 29c, LIC | ENSE N | UMBER | | 29d, DA | TE SIGNED | (Month, Day, Year) |
| 8 | 1 Com | 1 3-1 | 1/111 | UM | | 1) | 27 | 1400 | 3 | 1 5 | 7.1 | 185 |
| 2 | 30, NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF I | DEATH (ITEM 27) (Torn | e, Print) | | V | | , - | Į. | | | 177 |
| | | | , , , , , , , | | 17 | | | 011 | | | | |
| | Lawrence D. Boha | n 606 Dute | hman's | ane. | Eas | ron. | Md | 2160 | Ц | | | |
| | AUG 21 1995 | The division | NEWSON | | | | | | | | | |
| | | / [| | | | | | | | | | |



| | FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|--------------|-----------------------------------------------------|----------|
| _ | REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |

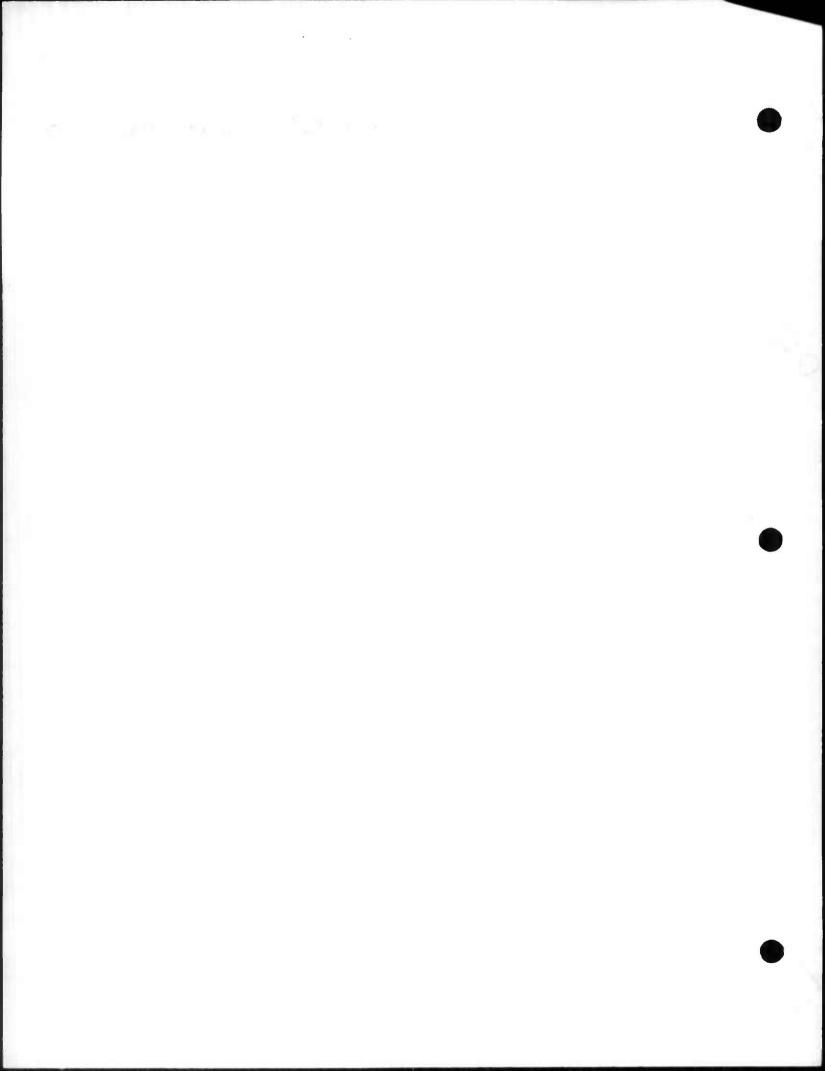
| | | 1 - STATE STATE OF MARYL | | RTMENT OF HEALTH AND | MENTAL HYGIEN REG. NO. | | | |
|-------------------------------------------------------------------------------------|-------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------|----------------------------------------|-----------------------------------------|------------------------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | ONE OF BEATT | 2. DATE OF DEATH | | 3. TIME OF DEATN | |
| | | | CHALL | | AUG. 11 | 1995 | 5:35 AM M | |
| | | | (In yrs. lest birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | HPLACE (State or Foreign | |
| pp | | | 83 YRS. | | MAY 5, | | | |
| 3 should | æ | 9e. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF E | EATH | 9c. COUNTY OF | | |
| 1. 2. | DIRECTOR | 25922 RIVER ROAD | | NEWCOMB | | TALBO | T | |
| Sec | RE | 10s. STATE 10b. COUNTY | 10c. CIT | Y, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? | |
| permit. Pages | | MARYLAND TALBOT 10e. STREET AND NUMBER | | NEWCOMB | | | 1 - YES 2 - X10 | |
| sit per | FUNERAL | 25922 RIVER ROAD | | 10f. ZIP CODE | | 7.1.7 | WHAT COUNTRY? | |
| 020 physician. burlat-transit | UNE | 11. MARITAL STATUS 12 WAS DECEDENT EVED IN | U.S. ARMED | 21653 13. WAS DECENDENT OF NISPA | NIC OBIGIN2 (Specify Yea | USA | E — American Indian. | |
| 5-0020 nding physic is the burial | | 1 Never Married 2 Married FORCES? 1 YES | 2 NO | Il yes, specify Cuban, Mexic 1 YES 2X NO Speci | en, Puerto Rican, etc.) | Biac Spec | ck, White, atc. | |
| | р Вү | 37 Wildowed 4 Divorced | | | | | WHITE | |
| | ETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S (Give kind of v life. Do NOT us | USUAL OCCUPATION work done during most of working | 18b. KIND OF BUS | SINESS/INDUSTRY | | |
| (4 E 5 | PLE | Elementary/Secondary (0-12) College (1-4 or 5+) | HOMEM | | OWN | HOME | | |
| The hospital detached for | COMPL | 17. FATHER'S NAME (First, Middle, Last) | понц | | AME (First, Middle, Maiden | | | |
| 3 2 Z | ш | EARL C. BURGESS | | ORPH | IA U. CUA | TT | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | 10 B | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING | ADDRESS (Street and Number or Rural | Route Number, City or Town | n, Stele, Zip Code) | | |
| | | BARBARA S. GRIFFITH | | BOX 163, NEW | | | | |
| BALTIMORE, after death. Page 6 may by by the funeral director, page moval. | | | | of DISPOSITION (Name of ther place) CEMETERY | | STON, M | | |
| Page al dire | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | I KING II | 22. NAME AND ADDRESS OF FA | ACILITY | | D | |
| BALTIMOR lsr death. Page 6 m the funeral director. val. | | * = | ^·- | NEWNAM FUNE | | | | |
| ca aft | | TOHO R. MERCFRON | the death. Do r | > 200 S. HARF | thea cerdiac or reani | , EASTO | N, MD | |
| non po | | anock, or heart failure. List only one ceuse on as | ach lina. | | | | Interval Between Onset and Death | |
| with with the cremation, the | | disease or condition resulting in death) | ve 14 | EARS FALL | uns | | 2 00 | |
| N 8 8 4 6 | | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | 211 | |
| and part | ON | Sequentially list conditions, | CONSEQUENCE OF | EARY FAIL' | RETU SA | 109 | 1/2 4/25 | |
| an be | RTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | CONSEDUENCE OF | · /- | | / | | |
| O. B ertificate ing phys giene p | Ē | CAUSE (Disease or Injury that initiated events resulting in deeth) LAST | | | | | | |
| e Hy | CER | d | | | | | | |
| DS the d | CAL | PART II. Other algnificent conditions contributing to deeth be | ut not resulting i | In the underlying cause given in | | | D. WERE AUTOPSY FINDINGS | |
| O - 6 E (8) | | | | | PERFOR | | AMILABLE PRIOR TO COMPLETION OF CAUSE | |
| L RECOF | MED | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | OF DEATH? 1 YES 2 NO | |
| ALR he law re has been Dept. or 23 sh | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | | | N 🗆 | | | |
| 三年 8 8 8 | SICIAN: | EXAMINER? / HOSPITAL: | 26. PLACE OF DEAT | OTHER: | | | | |
| II 오 호 후 | HYS | 1 ☐ YES 2. NO 1 ☐ Inpatient 2 ☐ ER/Output 27. MANNER OF DEATH 28a. DATE OF INJURY | atient 3 DOA | 4 ☐ Nursing Nome 5 Residence E OF 28c, INJURY AT | | LUISV COCURSO | | |
| ON OF ING PHYSIC fler this ce eath with the marked, | Y P | Netural 5 Pending (Month, Day, Year) | | WORK? WORK? | 28d. DESCRIBE HOW IN | NUNT OCCURED | | |
| 0 0 0 0 | 9 0 | 2 Accident Investigation 3 Suicide 6 Could not be 28a. PLACE OF INJURY building, atc. (Special Countries) | — At home, larm, s | | 281. LOCATION (Street a | and Number or Rural | Route Number, | |
| DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is mai | EIE | 4 Homicide detarmined | "77) | | City or Town, State) | | | |
| | 4 | 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge) | edge, desth occurre | ed at the time, date and place, and due | to the cause(s) end man | iner as stated. | | |
| TO THE HOSPITAL TO THE FUNERAL De filod within 72 IMPORTANT: It | COM | one) 2 MEDICAL EXAMINER: On the basis of examination | and/or investigation | n, in my opinion, death occured at the | time, data and placa, end | d due to the cause(| s) and manner as stated. | |
| THE HI fled wi | BE | 296. SIONATURE AND TITLE OF CERTIFIER | - | 29c. LICENSE NU | MBER | 29d. DATE SIGNED | (Month, Day, Ybar) | |
| 5 5 8 M | 5 | TO NAME AND ADDRESS OF DESCRIPTION | your | 10) 201 | 550 | 18-1 | 1-95 | |
| | | 30. NAME AND ADDRESS OF PERSON WHILE OMPLETED CAUSE OF DEA | 12 | | 73.6765 | NE 01 | 501 | |
| | | STEPHEN P. CARNEY, M.D., 31. DATE FILED (MONTH), Day, 1981, 1995 AUG 1 1995 | DUA TD | LEWILD AVENUE | , EASTON, | , MD 21 | 601 | |
| | | AUG 1 1 1995 | a confidence | | | | | |



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| 3 | E | afte afte | 500 |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after deat | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun- be filed within 72 hours after death with the State Dept. of Health and Mental Hopiene prior to burial, cremation, or removal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exam |
| 7 | AL (| 7 D D 2 | ======================================= |
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| | FOR | OTATE OF MAD | | | | | | | 50 | 4/199 | | |
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| | 1 - STATE REGISTRAR | STATE OF MAR | YLAND / DEF CERT | ARTMEN IFICAT | T OF I | DEATH AND | | NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | <i>a</i> . | | | 2. DATE OF DEA | TH | | 3. TIME OF DEATH | | |
| | Garrett | William | | ンキ | VEn | Soul | augu | 46 | 1995 | 2025 | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. last birtho | ay) IF UNDE | R 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTI (Month, Day, Y | Н | 8. BIR | THPLACE (State or Foreign | | |
| | 214-84-8868 | 1 M 2 - F | 35 YR | B. MONTHS | DAYS | HOURS MIN. | Nov. 1 | nar) | Cour | ntry) | | |
| | Se. FACILITY NAME (If not institution, give : | street end number) | | | | OR LOCATION OF D | | | | | | |
| TOR | PENINSULA REGIO | | SALISBURY WICOMICO | | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | Υ | 10c. | CITY, TOWN | OR LOCAT | TION | | | | 10d, INSIDE CITY | | |
| | Maryland Wor | cester | Snow Hill | | | | | | | LIMITS? | | |
| AL | 10e. STREET AND NUMBER | | Show | _ | r. ZIP CODE | | 1 | | 1 YES 2X NO | | | |
| A | | | | | 10 | - 11 | | 10g. | . CITIZEN OF | WHAT COUNTRY? | | |
| 岁 | P.O. Box 126 | <u> </u> | | | | 21863 | | | USA | | | |
| BY FUNER | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVE FDRCES? 1 Y IF YES, GIVE WAR O | TYER IN U.S. ARMED YES 2 TWO I OR DATES 13. WAS DECENOENT OF HI It yes, specify Cuben, M 1 YES 2 NO S | | | | tican, Puerlo Rican, etc.) Black, White, etc. | | | | | |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16e. DECEDEN | T'S USUAL C | CCUPATIO | ON | 16b. KIND 0 | F BUSINES: | S/INDUSTRY | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind life. Do NO | of work done IT use retired.) | during mo | st of working | 0.00 | | | | | |
| 립 | 10th | Jones (1-4 01 5 4) | Lin | e-Wor | kor | | Pou | 1+ | Plant | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | - | 1 1111 | E WOI | KET | 48 MOTHERIO N | | | | | | |
| _ | William Henry | Ca114ala | | | | | and the second | First, Middle, Maiden Surname) | | | | |
| BE | | COTITCK | | | | | Mae Cop | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City of | | | | | |
| | Lorenzo Collic | k | P. | 0. Bo | x 12 | 6, Snow | Hill, Ma | rylar | nd 21 | .863 | | |
| | 20e. METHOD OF DISPOSITION 1 N Burlai 2 Cremation 3 Rem | numl from State | 20h PLACE AND DA | TE OF DISPO | SITION /No | ama at | DATE 20 | C LOCATIO | N _ Clin or 1 | lown, State | | |
| 1 | 1 M Burlel 2 Cremation 3 Removed from State 4 Donation 5 Other (Specify) Coolspring U.M. Church Cem. 8/12/95 Girdletree, Md. | | | | | | | | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSES | | | | | | | | | | | |
| | Bennie Smith Funeral Services | | | | | | | | | | | |
| _ | | | | | P.0 | . Box 16 | 87, East | on, M | 1d. 21 | 601 | | |
| | 23. PART I. Enter the diseasea, or ahock, or heart failure. | Complications that cau | sed the deeth. D | o not ente | the mo | de of dying, suc | ch as cardiac or | reapirator | y arrest, | Approximate | | |
| | IMMEDIATE CAUSE (Finel | Liet only one cause of | | | | | 1 | 0 | | Interval Betwee | | |
| ŀ | disease or condition | in | mund deficiency | | | | | | | | | |
| l | resulting in death) | a. ACSC VOL OUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | |
| - | COLLO CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRA | | | | | | | | | | | |
| CATION | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| F | if any, leading to immediate cause. Enter UNDERLYING | 302 10 (011) | S A CONSEQUENC | L OF J. | | | | | | | | |
| 5 | CAUSE (Disease or Injury | | - 00 | | | | | | | | | |
| RTIFI | that initieted events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ш | d | | | | | | | | | | | |
| 2 | PART ii. Other eignificant condition | a contributing to deat | h but not regultic | o In the III | nderiving | n ceuse alven in | Part I Dan W | O AN AUTON | nev Ta | - WERE ALTROPOU COMMUNICATION | | |
| EDICAL | | | Total Total | ng in the o | dellyni | g caose given in | | REPORMED? | P31 24 | b. WERE AUTOPSY FINDING AMILABLE PRIOR TO | | |
| ă | | | | | | | 1 D Y | ES 2 N | 0 | OMPLETION OF CAUSE OF DEATH? | | |
| ME | 1 YES 2 NO | | | | | | | | | | | |
| | DID TOBACCO USE CONT | RIBUTE TO CAUSE | OF DEATH | YES 🗆 | NO E | UNCERTAI | N 🗆 📗 | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE DF D | EATH (Check | only one) | | | | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/0 | Sutpetient 3 DO | OTHE | | e E - Breidene | e C Other Count | | | | | |
| 主 | 27. MANNED-OF OEATH | 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residen 28s. DATE OF INJURY 28b. TIME DF 28c. INJURY AT | | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| ₽ | 1 Natural 5 Pending | (Month, Day, Yea | Day, Year) INJURY WO | | | ORK? YES 2 NO | | | | | | |
| B | 2 Accident Investigation | 28e PLACE OF IN II | | | | 201 0017/01/01 | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, fa | | | | tory, offic | • | 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) | | | | | |
| | | | | | | | | | | | | |
| ᆲ | 29e. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my kr | owledge, death occ | urred at the t | lme, data | end place, and due | to the cause(e) en | d manner ee | stated. | | | |
| COMPLE | CERTIFIEN (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data end piece, and due to the cause(e) end manner ee stated. MEDICAL EXAMINER: On the base of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(e) and manner ee stated. | | | | | | | | | | | |
| | 296. NGHATERIN AND TITLE OF CENTIFIES | | | -11 | | | | | | | | |
| BE | and from July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and July and Jul | | | | 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Da | | | D (Month, Day, Year) | | | | |
| <u>و</u> ا | A U Mar | ym | | | | 1251 | 6/4 | | 817 | (S) J | | |
| - 11 | on frame and anomaly or nessent un- | OFFICE ETEO CAUSE OF | | | | | | | | | | |

MIO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR STATE REGISTRAR

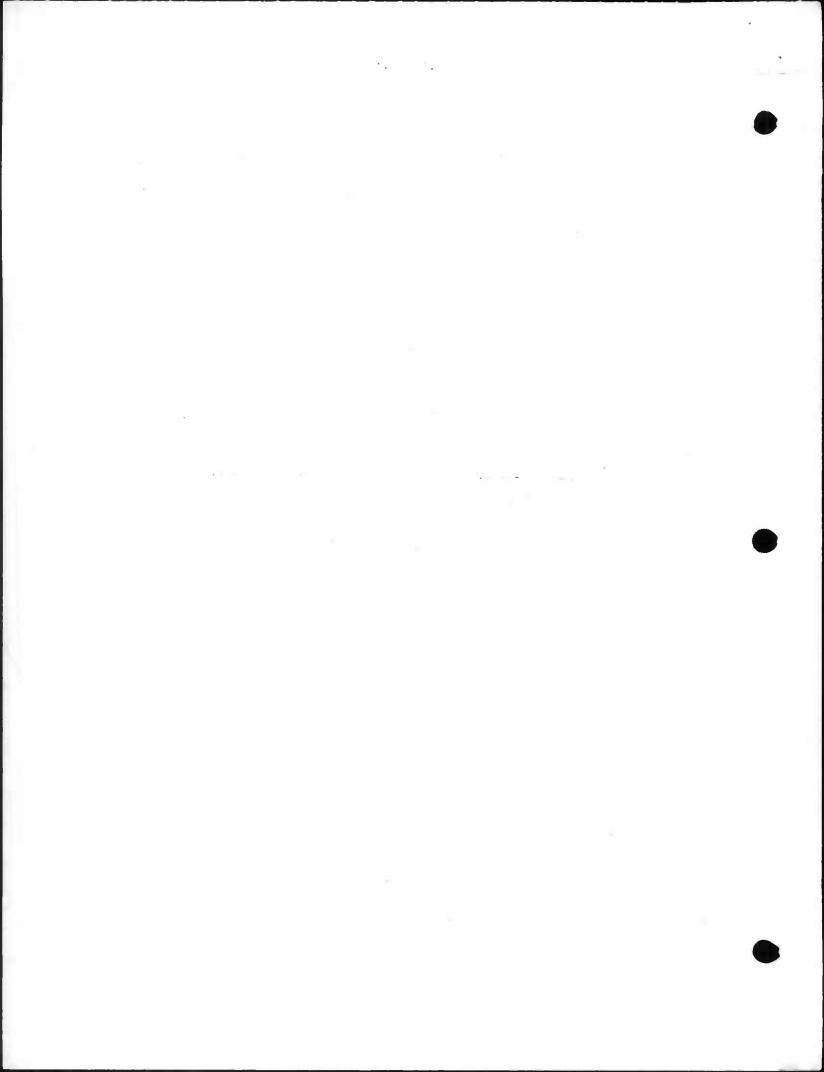
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | | REGISTRAR | | CERTIF | CATE C | F DEATH | REG. NO | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------|-------------------------|----------------------------------------------|-------------------------------------------------|------------------|--------------------------------------------------|--|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH DO | AY YE. | 3. TIME OF DEATH | | | | |
| | | GARLAND TA | YLOR SWAN | NN, SR. | | | AÜG. 23 | 1995 | 5:00 AM M | | | | |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (I | In yrs. lest birthday) | IF UNDER 1 YEA | | 7. DATE OF BIRTH | 8.8 | BIRTNPLACE (State or Foreign | | | | |
| 77 | | 215-36-2390 | 1 X M 2 □ F 80 | YRS. | MONTHS DAY | S HOURS MIN. | (Month, Day, Year) SEPT.3,1 | 914 N | IARYLAND | | | | |
| pinous | | 9a. FACILITY NAME (If not institution, give s | treet and number) | | 9b. CITY, TOW | N OR LOCATION OF D | | 9c. COUNTY | | | | | |
| 60 | OR | 11666 OLD COR | OOVA ROAD | | COR | DOVA | | TAT | вот | | | | |
| 1, 2, | RECTOR | RESIDENCE OF DECEDENT | | | | DOVI | | LAL | IDOI | | | | |
| Pages | 품 | 10a. STATE 10b. COUNTY | ! | 10c. CIT | r, TOWN OR LO | CATION | | | 10d. INSIDE CITY LIMITS? | | | | |
| H. | ā | | LBOT | | CORD | OVA | | | 1 TYES 2XXNO | | | | |
| Dec | 18 | 10e. STREET AND NUMBER | | | | 101. 2IP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | | |
| burial-transit permit. | FUNERAL | 11666 OLD CORI | | | | 2162 | 5 | US | A | | | | |
| nia-t | 5 | 11. MARITAL STATUS 1 Never Married 2X Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | 13. WAS (| DECENDENT OF HISPAI specify Cuban, Mexica | IIC ORIGIN? (Specify Yes | | RACE — American Indian, Black, White, etc. | | | | |
| the br | BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES AT | 101 | ES ZONO Specifi | /: | | Specify: | | | | |
| 60 | 0 | 15. DECEDENT'S EDUC | CATION | 18a. DECEDENT'S | | | | | WHITE | | | | |
| nge | ETE | (Specify only highest grade | 18b. KIND OF BUS | SINESS/INDUSTI | RY | | | | | | | | |
| Di Di | | Elementery/Secondary (0-12) | College (1-4 or 5 +) | | | | | | | | | | |
| detached once. | OMP | FARMER DAIRY & GRAIN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surregne) | | | | | | | | | | | |
| et de | Ü | JAMES ELMER | SWANN, SR. | | | 100000000000000000000000000000000000000 | | | TAD | | | | |
| phonic | 100 | 19a. INFORMANT'S NAME (Type/Print) | SHAMIN, SIX. | | ADDRESS /Sve | MINNI | E AMELIZ Route Number, City or Tow | | LOR | | | | |
| 5 5 | 일 | GEORGIA E. SWAN | ίΝ | | | | | | MD 21625 | | | | |
| page Pe | | 20e. METHOD OF DISPOSITION | | PLACE AND DATE O | | | | CATION — City | | | | | |
| | | 1 Donation 5 Other (Specify) | oval from State | etery crematory or of | her place) | PMFTFDV | | | | | | | |
| 6 6 | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | | | | |
| tuneral director, examiner mus | | MEI) | am DC | FSP. | | | RAL HOME | | | | | | |
| 0 2 | | | | | 200 | S. HARR | ISON ST. | EAST | ON, MD | | | | |
| d in by th or remove medical | | 23. PART I. Enter the diseeses, or c shock, or heart fellure. | complications that caused List only one cause on ea | the deeth. Do n och line. | ot enter the | mode of dying, auc | h as cardiac or reapi | iratory arrest, | Approximata Interval Between | | | | |
| filled in the m | | IMMEDIATE CAUSE (Finel | T | / |) | | | - | Onset and Death | | | | |
| cremation. | | disease or condition resulting in death) | . JULA | 100 | -NZ | DIDMY | PATTY | | YEARS | | | | |
| S -6 B | | | DUE TO (OR AS A | CONSEQUENCE OF |): | J | | | | | | | |
| 등 등 등 | NO N | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ician a for to | FICATION | If any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| attending physician mal Hygiene prior to Y, or other traun | 읪 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | 1: | | | | | | | | |
| Hygie Pr of | CERT | resulting in deeth) LAST | | | ,- | | | | Ì | | | | |
| the atte Mental Ijury, o | 빙 | | l | | | | | | | | | | |
| by the att and Menta iy injury, | AL | PART II. Other significent condition | | | n the underly | ring ceuse given in | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | |
| 9 E 9 | EDICAL | LENM | NSUFFICIEN | vay | | | 1 D YES 2 | | COMPLETION OF CAUSE OF DEATH? | | | | |
| of Hea | ME | | | | | | | | 1 WES 2 NO | | | | |
| as bee Sept. c | AN: | DID TOBACCO USE CONTR | RIBUTE TO CAUSE OF | F DEATH YE | S 1 NO | ☐ UNCERTAIN | 1 D | | | | | | |
| cate ha | CF | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | | ne) | | | | | | | |
| ntifica he Str | PHYSICI | 1 YES 2 NO | 1 Inpatient 2 ER/Outpa | Itlent 3 DOA | OTHER: 4 D Nursing N | Ioma 5 Residence | 8 D Other (Specify) | | | | | | |
| od, | F | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | | INJURY AT WORK? | 28d. DESCRIBE NOW II | NJURY OCCURE | D | | | | |
| fter this path with marked | Β¥ | 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | | | | | |
| R. Ar | 0 | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY - building, atc. (Specif | — At home, ferm, s | lreet, fectory, o | ffice | 28f. LOCATION (Street a City or Town, State) | and Number or Ru | iral Route Number, | | | | |
| THE FUNERAL DIRECTOR: After this certificate has been filed within 72 hours after death with the State Dept. of POPTANT: If item 28 is marked, or item 23 sho | ETE | 4 Nomicide determined | | | | | ony or rown, order | | | | | | |
| L DIRE hours | 4 | 29e. CERTIFIER (Check only | CIAN: To the best of my knowle | edge, death occurre | d at the time, d | ste and place, end due | to the cause(e) end man | ner as stated. | | | | | |
| VERAL Vin 72 | ŏ. | | R: On the basis of examination | | | | | | se(a) and manner as stated. | | | | |
| d with | m C | 290. SUGNATURE AND TITLE OF CERTIFIES | 7 / | | | 964-LICENSE NUM | | | | | | | |
| TO THE FUNER. be filed within 7 IMPORTANT: | œ | Tuesday 1238/2 29d. DATE SIONED (North, Day, Year) | | | | | | | | | | | |
| -0= | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, | Print) | | 0 | 0 | 1.15 | | | | |
| - | | JOOR O FRIGOMAN MD 403 MARVEL CT. EASTON, MO ZIGO) | | | | | | | | | | | |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | | | | | | | | | |
| I | | AUG 2 5 1995 | Halin Davidson | Mardall | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | | OF HEALTH AND I | MENTAL HYGIEN REG. NO. | | | | | |
|-----------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------|------------------------|--------------------------------------------------------------------------|-------------------------------------------------|-----------------------|-------------------------------------------------------------------------|--|--|--|
| : | | | ELIZABETH S. | . SCHU | L | | AUGUST 19 | 7 1995 ^{YEA} | 3. TIME OF DEATH 0700 M | | | |
| , | | 4. SOCIAL SECURITY NUMBER 218-09-9941 | 1 🗆 M 2 🔀 F | (In yrs. last birthd | S, MONTHS | DAYS HOURS MIN. | 7. DATE OF BIRTH | 0. Bit | RTNPLACE (Stetle or Foreign | | | |
| | TOR | 90. FACILITY NAME (If not institution, give s 5 CHURCH STREET RESIDENCE OF DECEDENT | treet and number) | | | RLIN | EATN | WORCES | | | | |
| | DIRECTOR | 10a. STATE 10b. COUNT | ESTER | 10g | CITY, TOWN OR ERLIN | LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| | FUNERAL | 100. STREET AND NUMBER 5 CHURCH STREE | Т | | | 101. ZIP CODE 21811 | 1 | USA | F WHAT COUNTRY? | | | |
| | TO BE COMPLETED BY FUR | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 40 | 14 | AS DECENDENT OF HISPAN res, specify Cuban, Maxica YES 2 NO Specify | n, Puerto Rican, atc.) | В | ACE — American Indian, lack, White, atc. | | | |
| aš | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) 12 16c. NIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16c. NIND OF BUSINESS/INDUSTRY | | | | | | | | | | |
| ed at once. | | JOHN PACKER HETTY CAREY | | | | | | | | | | |
| be notified | | 190. INFORMANT'S NAME (Type/Print) MILTON J. SCHUL 190. MAILING ADDRESS (Street and Number or Parel Route Number, City or Town, State, Zip Code) 908 HIP POCKET RD., PEACHTREE CITY, GA., 30269 | | | | | | | | | | |
| must | | 20s. METHOD OF DISPOSITION 1 | | | | | | | | | | |
| or removal. medical examiner | | · Shull | Mil | | ULt | RICH FUNER | AL HOME BI | ERLIN, I | Mp. | | | |
| | | 23. PART 1. Enter the diseases, or a shock, or heert failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | eCu | isch line. | ine | Heart | talu | ratory errest, | Approximate interval Between Onset and Deeth | | | |
| prior to burial, cremation, traumatic event, the | ATION | Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING DUE TO (OR AS A CONSCOURAGE OF) DUE TO (OR AS A CONSCOURAGE OF) | | | | | | | | | | |
| tal Hygiene pr | CERTIFICATION | CAUSE (Disease or injury thet initiated events resulting in death) LAST | de events C. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ith and Menta any Injury, | EDICAL C | PART II. Other significant condition | s contributing to death b | out not resulting | ng in the und | erlying ceuse given in | Part I. 24a. WAS AN PERFOR | IMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| Dept. of Health at 23 shows any | AN: MED | DID TOBACCO USE CONTI | RIBUTE TO CAUSE C | OF DEATH | YES N | O UNCERTAIN | | 7 | of DEATH? | | | |
| the State De | YSICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outs | 26. PLACE OF D | OTHER: | g Home 5 Tresidence | 6 Other (Specify) | | | | | |
| marked, | ву Рн | 27. MANNER OF DEATN 1 Natural S Pending 2 Accident investigation | 28a. DATE OF INJURY (Month, Day, Year) | | INJURY M | Bc. INJURY AT WORK? | 28d. DESCRIBE NOW II | NJURY OCCURED | | | | |
| hours after death with item 28 is marked | ETED. | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, atc. (Spec | crfy) | | | 28f. LOCATION (Street a City or Town, State) | | al Route Number, | | | |
| 2 == | COMPL | anal . | CIAN: To the best of my know | | | | | | ne(s) and menner as stated. | | | |
| be filed within | TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIES | Witer | WE | 2 | 29c. LICENSE NUN | 1993 | | ED (Month, Day, Year) | | | |
| | 5 | 30. NAME AND ADDRESS OF PERSON WN STEPHEN F. WATER 31. DATE FILED (Month, Day, Year) | RS, M.D. 100 | Ol PHIL | A. AVE. | , OCEAN CI | ry, MD. 218 | 842 | | | | |
| | | AUG 22 1995 | 3. REGISTRAR'S SIGN | - Russel | | | | | | | | |



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DIRECTOR

FUNERAL

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L DIRECTOR: After the hours after death vitem 28 is mark

TO THE HOSPITAL OF THE FUNERAL DE FIRED WITHIN 72 h HOSPITAL

CERTIFICATION

PHYSICIAN: MEDICAL

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3 Sulcide

4 Homicide

ITEMS: 23 PART I, 27, PER MEO FILM G-728 10/6/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR

| REGISTRAR | | CERTIF | ICATI | E OF | DEA | ГН | REG. NO. | | | | |
|--------------------------------------------------|--------------------|--------------------------------|---------|---------|-----------|----------|---------------------------|---------------|----------|--------------------|---------|
| DECEDENT'S NAME (First, Middle, Last) BALLA SEKO | | IBE | | | | | 2. DATE OF DEATH AUGUST 1 | 9,1 | 995 | 3. TIME OF DE 0930 | |
| SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. last birthday) | | T | IF UNDER | 1 | 7. DATE OF BIRTH | | | IPLACE (Stelle or | Foreign |
| 220-19-4141 | XX M 2 D F | 11 YRS. | MONTHS | DAYS | HOURS | MIN. | APRIL 12, | 84 | | HINGTON | I, DC |
| . FACILITY NAME (If not institution, give : | street end number) | | 9b. CIT | r, TOWN | OR LOCATI | ON OF DE | EATH | 9c. COU | NTY OF D | EATH | |
| RINCE GEORGES | AL CENTER | CHI | EVE | RLY | | | PR | INCE | E GEOR | GES | |
| ESIDENCE OF DECEDENT | | | | | | | | | | | |
| - CTATE - 10h COUNT | W TOWNS | OBLOCA | TION | | | | | 104 INSIDE CI | TV | | |

P RI Oc. CITY, TOWN OR LOCATION LIMITS? TY YES 2 NO PRINCE GEORGE'S LANDOVER MARYLAND 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 20785 7721 MERRICK LANE 14. RACE --- American Indian, Black, While, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No---

11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO Never Merried 2 Merried 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION

College (1-4 or 5+)

If yes, specify Cuben, Mexican, Puerlo Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: BLACK 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.)

18. MOTNER'S NAME (First, Middle, Maiden Surname)

PRIVATE

17. FATHER'S NAME (First, Middle, Last) BALLA SEKOU SIDIBE, SR.

Flementary/Secondary (0-12)

6th

(Specify only highest grade completed)

DOTILDA JOSEPH 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)

190, INFORMANT'S NAME (Type/Print) BALLA SEKOU SIDIBE (FATHER) 7721 MERRICK LANE; LANDOVER, MARYLAND 20785 20a. METNOD OF DISPOSITION

STUDENT

20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE HARMONY MEMORIAL PARK 8-25-95

22. NAME AND ADDRESS OF FACILITY

LANDOVER, MARYLAND

Approximata

1 YES 2 NO

Onset and Death

1 Donation 8 Other (Specify) GLENDA M.

JOHNSON & JENKINS FUNERAL HOME, INC INC. 716 KENNEDY STREET, N.W.: WDC

23. PART I. Emer the diseases, or combigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, hock, or heart failure. List only one couse on each line. IMMEDIATE CAUSE (Fine) disease or condition

CONGENITAL BRAIN STEM ABNORMALITY COMPLICATED BY ATYPICAL

PNEUMONIA OUE TO (OR AS A CONSEQUENCE OF):

Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

resulting in death)

DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):

PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 PEYES 2 NO

281, LOCATION (Street end Number or Rural Route Number, City or Town, State)

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATN (Check only one) HOSPITAL: ☐ Inpetient 2X ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify)

EXAMINER? 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 1XX Natural 5 Pending 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)

28b. TIME OF 28c. INJURY AT WORK? 26d, DESCRIBE NOW INJURY OCCURED 1 YES 2 NO

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) and menner ee stated.

2 X MEDICAL EXAMINER: On the basis million and/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

O.C.M.E

AUGUST 20,1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Javid ler 32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) AUG 22 1995 di hurden Kardall

8 Could not be

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Pages 1, 2, 3 should

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page 5 should be

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filled in

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requires that the death

OR ATTENDING PHYSICIAN: The law

and com traumatic

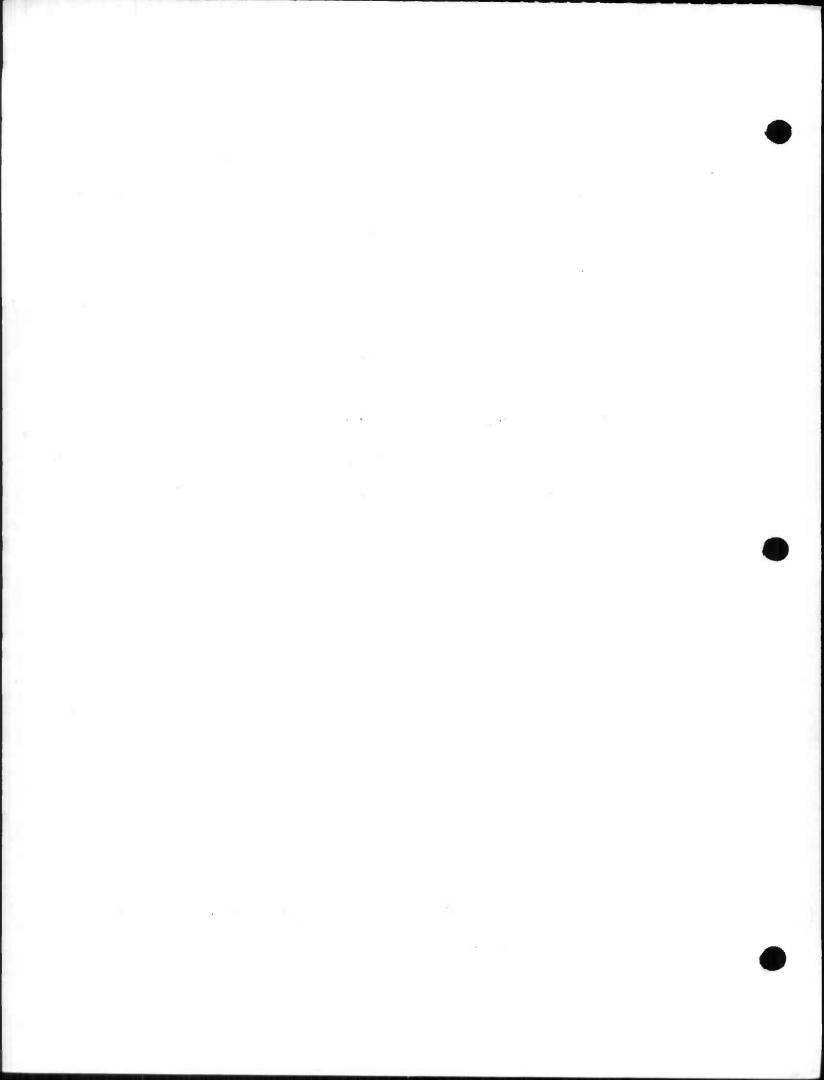
the attending physician Mental Hygiene prior to

and and any s been signed b

this certificate has b with the State Dept.

0

BOX 68760 RECORDS, P.O. **DIVISION OF VITAL**



5

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Krishan Mathur, MD.11340 Pembrooke Square Suite 213 Waldorf, Maryland 20603

31. DATE FILED (MONTH, Day 18) 1995

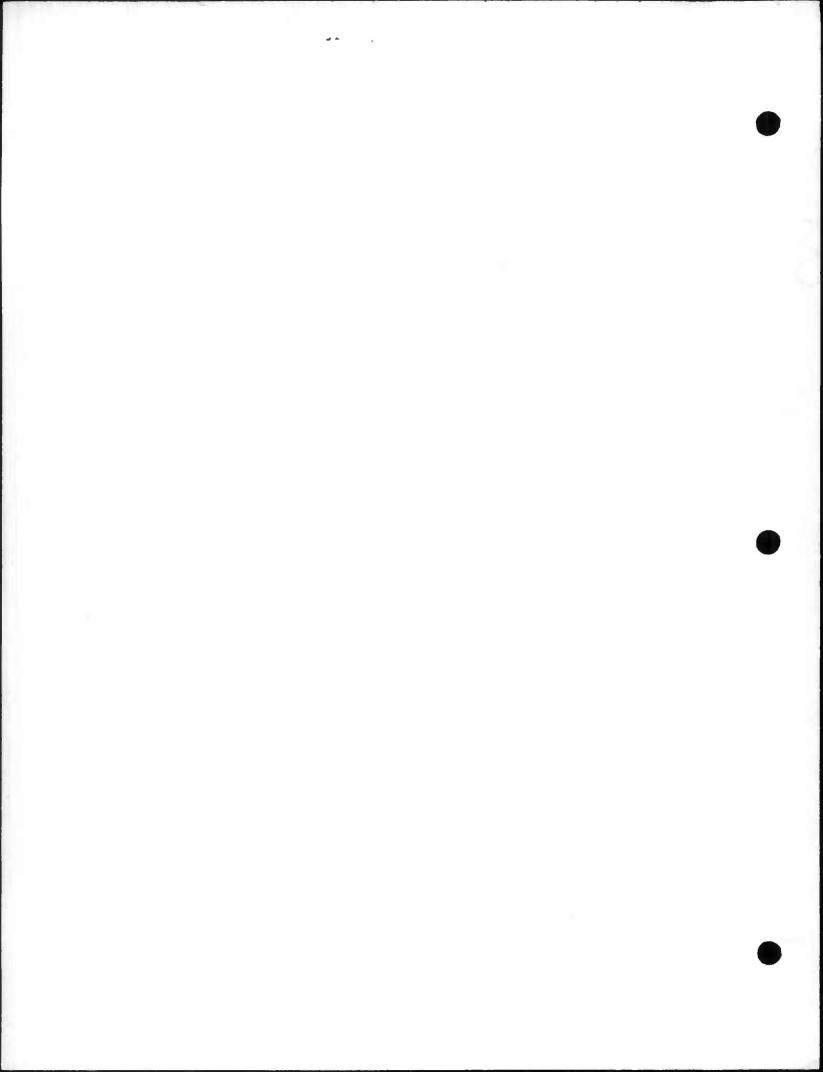
32. BEGISTARIS SIGNATURE

Suita Division Review

| | 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR CERTIF | TMENT OF | F HEALTH AND I | MENTAL HYGIE | NE | Can 1 | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------|----------------------------------|---------------------------------------------------------------------|----------------------------------------------|---------------------|---------------------------------------------|-----------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Morris Colbe | | | | cott | 2. DATE OF DEATH MONTH August 24, | | VEAR | e of death 25 P | | |
| | | 5. SEX 6. AGE (In | 79 YRS. | IF UNDER 1 YE | AR IF UNDER 24 HRS. PS HOURS MIN. | 7. DATE OF BIRTH | 1916 | County D | (State or Foreign | | |
| TOR | 98. FACILITY NAME (If not institution, give street 6130 Bicknell R | | | 96. CITY, τον Pisg | vn or location of de ah | EATN | | rles | | | |
| DIRECTOR | Maryland Charles | | I | y, town on Lo an Head | OCATION | | | U | NSIDE CITY IMITS? YES 2 NO | | |
| FUNERAL | 6130 Bicknell Road (Re | | | | 101. ZIP CODE 20640 | | U. | S.A. | DUNTRY? | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | If yes | DECENDENT OF NISPAN , specify Cuban, Maxica YES 2 ZNO Specify | n, Puerto Ricen, etc.) | es or No— 1 | 4. RACE — Ame Black, White Specify: W | , etc. | | |
| PLETED | 15, DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) | college (1-4 or 5+) | | work done during se retired.) | ATION I most of working | U.S. G | | | | | |
| E COMPLET | 17. FATHER'S NAME (First, Middle, Lest) John Thomas Sco | tt | Automo | DITE! | 18. MOTHER'S NA | ME (First, Middle, Maide | | cott | | | |
| 10 B | John Thomas Scott Medie Alma Speake Scott 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Paral Route Number, City or Town, State, Zip Code) 10980 Barry Rd. Waldorf, MD 20603 | | | | | | | | | | |
| | 20e. METNOD OF DISPOSITION 1 Seriel 2 Cremation 3 Remove 4 Donatton 5 Other (Specify) | | LACE AND DATE | | Gardens 8 | | Waldo | rf, MD | ta | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | 0945 | ARE P.O | HART-ECHO | OLS FUNE 7 LaPlat | | | NC. | | |
| | 23. PART I. Enter the disease, or core ahock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death) | mplications that caused at only one cause on each | h line. | | mods of dying, auc | h aa cardiac or rea | olratory arres | it, | Approximate interval Between Onset and Dea | | |
| CERTIFICATION | 22 5 7 2 7 2 7 2 7 2 7 2 7 2 7 2 7 2 7 2 | | | | | | | | | | |
| MEDICAL CE | PART II. Other significent conditions | contributing to death but | not resulting l | n the underl | ying ceuse given in | | RMED? | AWAILA | AUTOPSY FINDING BLE PRIOR TO ETION OF CAUSE ATH? | | |
| | DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL | | DEATH YE | | | N [] | | 1 🗆 Y | ES 2 NO | | |
| PHYSICIAN: | EXAMINER? | Inpatient 2 ER/Outpat | | OTHER: | 0 | 6 Other (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | | M t | WORK? YES 2 NO | 28d. DEŞCRIBE NOW | | | | | |
| ETED | 3 Suicide 6 Could not be 4 Homicide detarmined | 28s. PLACE OF INJURY — building, etc. (Specify | - At home, ferm, s | straet, factory, c | ffica | 26f. LOCATION (Street City or Town, State | and Number or)) | Rural Route Nu | mber, | | |
| COMPLI | | N: To the best of my knowled On the basis of examination a | | | | | | | enner aa stated. | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 | Man. | | 29c. LICENSE NUM | IBER | 29d. DATE S | SIGNED (Month, | | | |

D-28352

18-25-91



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages | iours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| OR ATTENDING PH | DIRECTOR: After th | w death w | tem 28 is mark |
| TO THE HOSPITAL | TO THE FUNERAL | be filed within 72 I | IMPORTANT: IF |

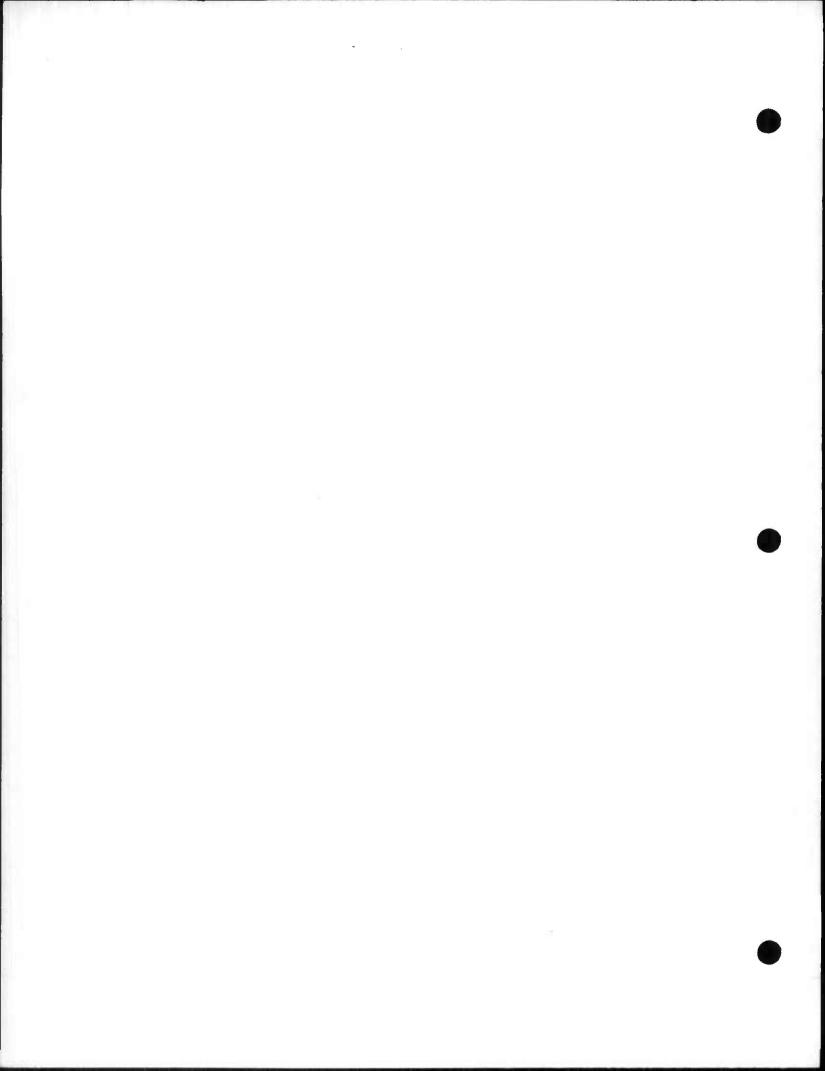
| | | | | | 4 | | | | | | | 9 | 5 | 27 | 201 | ł | |
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| | for STATE REGISTRAR | | STATE OF I | | / DEPAR | | | | | MENT | AL HYGI | | | | | | |
| | 1. DECEDENT'S NAME (First Charles | | Thomas | S | mith S | r. | | | | 2. DAT AMON | ust 24 | Н | YEAR | 3. TIM 6:25 | | Н | |
| | 4. SOCIAL SECURITY NUMBER 196-01-192 Sec. FACILITY NAME (If not in | 21 | 5. SEX 1 X M 2 F | 6. AGE (In yrs. 86 | vRS. | MONTHS | | IF UNDER | MIN. | May | E OF BIRTH ofth, Day, Yea 7 31 | , 190 | 9 P∈ | nns | | | |
| TOR | 7396 Woodhave | n Dr. | treet and number) | | | | Plata | OR LOCATI | ON OF D | EATH | | | | | | | |
| DIRECTOR | Maryland | 10b. COUNTY | arles | | 10c. Ci1 | , | or local | | | | | | | LI | MITS? | | |
| FUNERAL | 7396 WOO | dhave | | | | | | 2064 | 6 | | | U | S.A | ١. | | | |
| В | 1 Never Married 2 3 Widowed 4 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 S | ARMED NO | 13 | If yes, sp | CENDENT Concepts of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of t | n, Maxica | in, Puarte | NN7 (Specify o Rican, atc. | Yes or No— | Ble | | ACE (State or Foreign Insylvania) Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania Insylvania | | |
| COMPLETED | 15. DEC (Specify only Elementary/Secondary (0 | CATION completed) Coffege (1-4 or 5 | +) | GECEDENT'S (Give kind of the Do NOT u | work done se retired. | during mo | ON ost of working | ng | | | Nav | Navy | | | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Willard Leighton Smith 18. MOTHER'S NAME (First, Middle, Meiden Surname) Sarah Margaret Thomas Smith | | | | | | | | | | | | | | | | |
| 10 | 19a. INFORMANT'S NAME (Typer/Print) Charles T. Smith, Jr. 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 7396 Woodhaven Drive La Plata, MD 20646 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, State | | | | | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSIT. 1 Buriel 2 Crematic 4 Donation 6 Other 21. SIGNATURE OF FUNERA | (Specify) | | 20b. PLAC cerretery, of MC L1 | rematory or COPO I | ither place | n C | rema | | y 8 | / 2 5 | Alexa | andr | ia, | VA | | |
| | - Tangi | In a | - Cehil | 00817 | | | Are P.O | hart Bo | -Ec | hol 67 | La P | lata | MI | me, 20 | Inc 646 | 2. | |
| | 23. PART t. Enter the di ahook, or hi IMMEDIATE CAUSE (Fir disease or condition resulting in death) | aart fallure. | a. OTO | t caused that ise on each life (OB AS A CONS | J. 1. | E | r the mo | P) | AC | A . A | ALL | urf | rreat, | Ir | tarvel Be | etween | |
| TIFICATION | Sequantially list condition in any, leading to immediate. Enter UNDERLY! | diate NG | OFF | AEN | EQUENCE O | D | HY. | 10 | N | hi | 17 | (H) | / :d)(| V | | | |
| CERTIFI | that initiated events resulting in death) LAS | 1 | s. Due to | BE | EQUENCE O | F): | 1(| PA | P | 28 | AT | Key | 4 | / | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnifice | nt condition | e contributing to | death but not | resulting | in tha u | ndarlyin | g cause g | lven in | Part i. | PER | AN AUTOPSY FORMED? | 24 | COMPLI OF DEA | LE PRIOR 1 ETION OF C TH? | AUSE | |
| CIAN: | DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? | | HOSPITAL: | | ATH YE | TH (Check | only one) |] UNC | ERTAI | V 🗆 | | | | | | | |
| BY PHYSI | | Pending Investigation | 1 Inpetient 2 28e. DATE OF (Month, D | INJURY | 28b. TIM | | 28c. INJ WO | | | | er (Specify) | W INJURY O | COURED | | | | |
| | 3 Suicide 8 | Could not be | 28e. PLACE O building, | F INJURY — AI I | nome, farm, | street, fac | ctory, offic | • | | 28f. LO Cit | CATION (Str y or Town, St | pet and Numberate) | OUNTY OF DEATH DATIES 10d. INSIDE CITY LIMITS? 1 YES 2 NO EXTIZEN OF WHAT COUNTRY? S. A. 14. RACE — American Indian, Stachy; White INDUSTRY Ty Omas Smith Tip Code) a, MD 20646 — City or Town, State andria, VA 1 Home, Inc., MD 20646 arreat, Approximate Interval Between Onset and Death Ty 24b. WERE AUTOPSY FINDINGS AMILLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DOCCURED Der or Rural Route Number, Intered. Intered. The cause(a) and manner as stated. | | | | |
| COMPLETED | | | CIAN: To the beat of R: On the basis of a: | | | | | | | | | | | (a) and ma | nner aa st | ated. | |
| TO BE | 296. SIGNATURE AND THE OF CERTIFIER 296. LICENSE NUMBER D-23021 297. NAME AND ADDRESS OF RESSON WAS COMPLETED CAUSE OF DEATH OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERT | | | | | | | | | | | | | | | | |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Sanjeeb Mishra MD 7C post Office Road Cenna Center Waldorf, MD. 20602

31. DATE FILED GHOSTIN ON WASHINGTON

32. REMISTRAR'S SIGNATURE
JULIA DRUMBER RONDOLL



Township, Pa.

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO

Hoad Md 206 10
Approximate
Interval Batween
Onset and Death

3:45 p M

2

William

AIIC 2 9 1995

31. DATE FILED (Month, Day, Year)

1 - STATE REGISTRAR

| 2, 3 should | OR | Anna 4. SOCIAL SECURITY NUMBER 211-14-2889 9a. FACILITY NAME (If not institution, give | 5. SEX 1 M 2 F street and number) | e. AGE (In | yrs. last birthday) YRS. | | TOWN C | F UNDER 24 HRS HOURS MIN. OR LOCATION OF | Augu 7. DATE (Mon | of BIRTH | 1995 1908 | Penr TY OF DI | sylvania EATH | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------|-------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------|------------------------|-----------------------------|-----------------------------------------------------------------------------------------|-------------|------|------------------------------------------|
| 21215-0020 I or attending physician. or use as the burial-transit permit. Pages 1. | APLETED BY FUNERAL DIRECTOR | 6574 Cornell Road RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Char 10a. STREET AND NUMBER 6574 Cornell Road 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 15. DECEDENT'S ED (Specily only highest grad Elementary/Secondary (0-12) | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES WAR OR DAT | J.S. ARMED 2 NO ES (Be. DECEDENT'S (Give kind of life. Do NOT u | 13. W If 1 susual occurred.) | AS DEC | 20616 20616 ENDENT OF HISP secify Cuban, Maximum Spe SN st of working | PANIC ORIGI Ican, Puerto clly: | Ricen, etc.) | 10g. CITIZ U a or No— | 14. RACE Black Specif | 10d. INSIDE CITY LIMITS? 1 YES 2X NO PHAT COUNTRY? A. — American Indian, , Whita, stc. | | | |
| ALTIMORE, MARYL death. Page 6 may be retained by e funeral director, page 5 should be bl. | O Cleaning Lady Realty 17. FATHER'S NAME (First, Middle, Last) Nick Ostoffy 18. MOTHER'S NAME (First, Middle, Melden Surname) Nick Ostoffy 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code Mary Ann Cindrich 20b. PLACE AND DATE OF DISPOSITION (Name of Light Place) 20b. PLACE AND DATE OF DISPOSITION (Name of Light Place) August 30, 199 50c. LOCATION — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor or Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Place of Location — City of Commellor of Location — City of Commellor of Location — City of Commellor of Location — City of Commellor of Location — City of Commellor of Location — City o | | | | | | | | | | Code) City or Ton 7 TO | wnship, Pa | | | | |
| P.O. BOX 68760 th certificate be executed within 24 hours after the physician and completely filled in by a li Hyglene prior to bunal, cremation, or remoor of other traumatic event, the medical | CERTIFICATION | CERTIFICATION | | | 23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. A Cult DUE TO b. DUE TO c. | (OR AS A C | th line. | (; a/ p) f): | | | uch aa car | diac or reapi | ratory arre | ant, | Approximate Interval Batwe Onset and Des |
| DIVISION OF VITAL RECORDS, F OR ATTENDING PHYSICIAN: The law requires that the death DIRECTOR: After this certificate has been signed by the atten hours after death with the State Dept. of Health and Mental liem 28 is marked, or item 23 shows any injury, or | TED BY PHYSICIAN: MEDICAL | PART II. Other algnificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined | RIBUTE TO CA HOSPITAL: 1 Inpettent 2 28e. DATE OF (Month, D) | ER/Outpatl INJURY ay, Year) | DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH YI DEATH | TH (Check or OTHER: 4 Nursid | nly one) ing Home Rec. INJI WO 1 | UNCERTA 5 TRasidence UNITY AT RKY ES 2 NO | 0 8 Oth | 24a. WAS AN PERFOR 1 YES 2 or (Specify) SCRIBE HOW II CATION (Street a or Town, State) | MED? | URED | WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC be filed within 72 hours IMPORTANT: If Item | O BE COMPLE | | | xamination a | | | | | UMBER | and place, an | d due to the | cause(a) | and menner as stated. (Month, Day, Year) | | | |

30. NAME AND APPRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

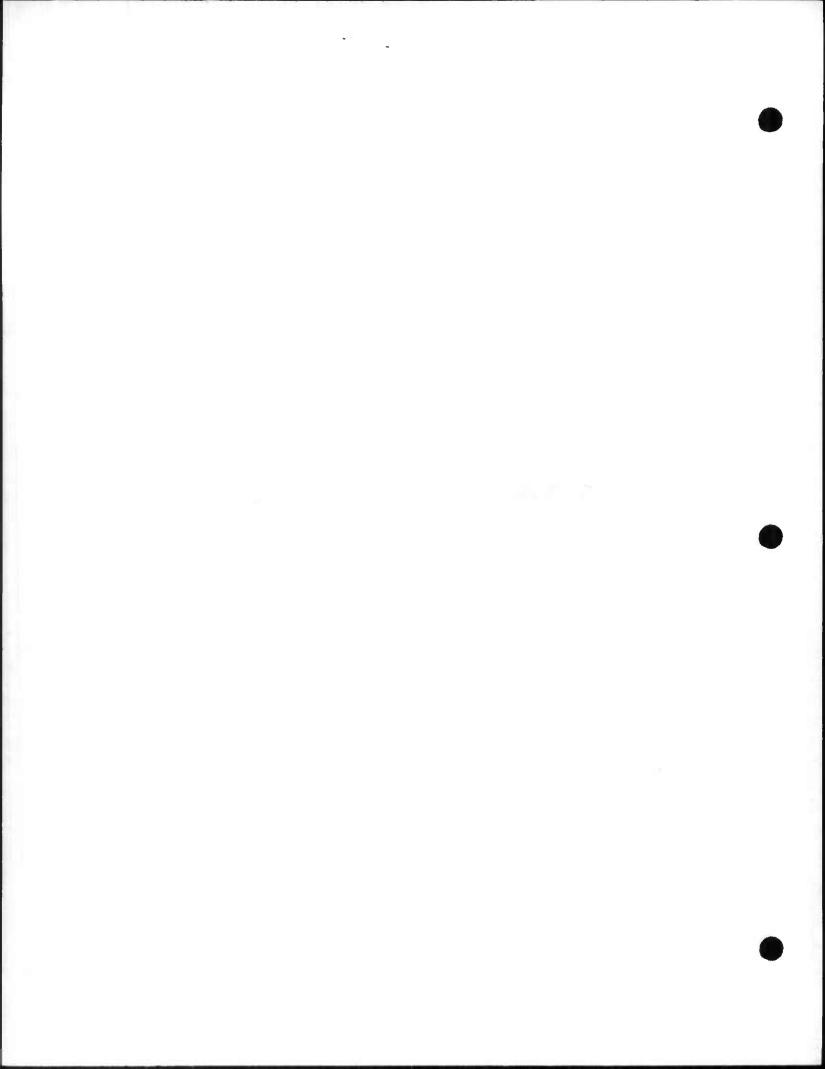
TAnner My

32. REGISTRARY SIGNATURE
Julia d'Aurelson Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Ft WASHington, was

11701 Livington KD.



Pages 1, 2, 3 should

permit.

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit | be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|

95 27206 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lust) 2. DATE OF DEATH 1325 Aug. 08 ~~25 95 GREGORY ROBERT SHORT 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday, IF UNDER t YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Now. 5,1967 212-04-2998 Maryland 1 X M 2 - F 27 Sa. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 15285 Sunset Drive Hughesville DIRECTOR Charles RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Charles Hughesville Maryland 1 YES 2 NO 10a, STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15285 Sunset Drive 20637 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No—If yes, specify Cuben, Maxicon, Puerto Rican, etc.)

1 YES 2 N NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Construction Elementary/Secondary (0-12) College (1-4 or 5 +) Bricklayer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecila Ann Chappelear Robert Louis Short BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6084 Macs Hollow Road, Prince Frederick, Md 20678 Robert L. Short 20a, METHOD OF DISPOSITION
1 A Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE St. Mary's Cemetery 4 Donation 5 Other (Specify) Aug. 28 Bryantown, Maryland 21. SIGNATURE OF PUNERAL SERVICE LICENSEE The Huntt Funeral Home BENJAMIN M. MATTHEWS M00658 P.O. Box 156, Waldorf, MD. 20604 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** of Cernical Spinal Cord disease or condition resulting in death) everation 11) Stutakeon DUE TO (OR AS A CONSEQUENCE OF) Shot Wound. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate pression cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: YES 2 NO 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dash occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. MP TITLE OF CERTIFI 29b. SIGNATURE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Deputy Med Examing D46419 25795 M 5

700 Old Line Centre #100 Waldorf

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Charlene

AUG 2 9 1995

31. DATE FILED (Month, Day, Year)

A Letchford MD

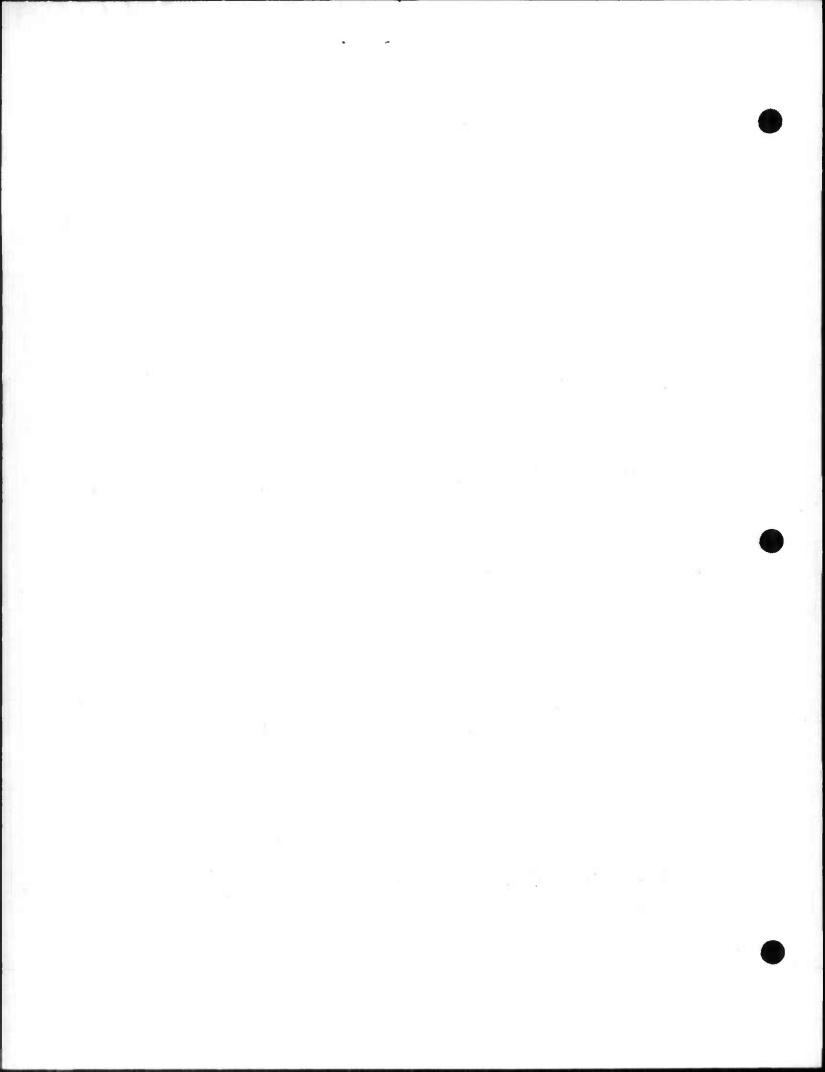
32. REGISTRAR'S SIGNATURE
HULL O'MULLON-RONALL

20602

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

| | 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | MENT OF H | EALTH AND DEATH | MENTAL HYGIE | | | | | | |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------|---------------------------------|---------------------------------------------------------|------------------------------------------------|------------------------|----------------------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | George Edwa | rd Shor | b | | 2. DATE OF DEATH MONTH August | 2°7 1951 | 3. TIME OF DEATH 5 10:54 p. M | | | | |
| | 4. SOCIAL SECURITY NUMBER 213-42-7530 | 1 🔀 M 2 🗆 F 54 | YRS. | IF UNDER 1 YEAR ROHTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | Co | HTHPLACE (State or Foreign Suntry) Maryland | | | | |
| 10R | 94. FACILITY NAME (II not institution, give Ft. Washington A | | 1 | 9ь сту, тожн о Ft. Wasl | | DEATH | Prince | e George's | | | | |
| DIRECTOR | 10a. STATE 10b. COUR | NTY | 10c. CITY, | TOWN OR LOCATI | ON | | 10d. INSIDE CIT | | | | | |
| | Maryland Pr. | George's | A | ccokeek | | | | 1 TYES 2 NO | | | | |
| FUNERAL | 15773 Livingston | Road | | 101. | ZIP CODE 2060 |)7 | 10g. CITIZEN C | DE WHAT COUNTRY? | | | | |
| 8 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | If yes, spe | ENDENT OF HISPA city Cuban, Mexico 2 ☑ NO Special | NIC ORIGIN? (Specify Vien, Puerto Ricen, etc.) | 0 | ACE — American Indian, lleck, White, etc. | | | | |
| OMPLETED | 15. DECEDENT'S Ec (Specify only highest gra | DUCATION ide completed) College (1-4 or 5+) | life. Do NOT use | rk done during mos retired.) | N t of working | | JSINESS/INOUSTR | | | | | |
| OMP | 17. FATHER'S NAME (First, Middle, Last) | | Mechan | ic | 40 MOTHERIO NA | | motive | | | | | |
| BE CC | Joseph Edward Sh | orb | | | | AME (First, Middle, Meide L Eloise At | | | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | | d Number or Rural | Route Number, City or To | wn, State, Zip Code, | | | | | |
| 2 | Ethel Woodall 15773 Livingston Rd., Accokeek, MD 20607 | | | | | | | | | | | |
| T BREE | 20b. PLACE AND DATE of DISPOSITION DATE 20c. LOCATION - City or Town, State Camellon 3 Removal from State Camellon 5 Other (Specify) Trinity Memorial Gardens 8-31 Waldorf, MD | | | | | | | | | | | |
| examiner must | 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-015 | | | | | | | | | | | |
| medical e | 23. PART f. Enter the diseases, o | r complications that caused t | the daeth. Do no | P. O. | Box 156 | Waldorf | MD 206 | 04-0156 | | | | |
| 200 | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Hypertensive arteriosclerotic cardiovascular **DMEXIXON NO NO NO NO NO NO NO NO NO NO NO NO N | | | | | | | | | | | |
| , even | | - disease | KONEGOUENKEXOPY. | X | | | | | | | | |
| TIFICATION | Sequentielly list conditions, if any, leading to immediate | DUE TO (OR AS A C | ONSEQUENCE OF): | | | | | | | | | |
| E S | cause. Enter UNDERLYING C. CAUSE (Disease or Injury that initiated wagets DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 5 K | that initiated events resulting in death) LAST | d | | | | | | | | | | |
| AL CE | PART II. Other algnificant condition | ons contributing to death but | not resulting in | the underlying | cause given in | Part I. 24e. WAS A | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | |
| | | | | | | | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| MEDIC | | | | | | | | OF DEATH? | | | | |
| AN: | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | | DEATH YES | | UNCERTAI | N 🗆 | | | | | | |
| YSICI, | EXAMINER? 1 Xes 2 No | HOSPITAL: 1 Inpetient 2 XER/Outpeti | _ 0 | THER: | 5 Realdence | 6 Other (Specify) | | | | | | |
| BY PHYSICIAN: MEDIC | 27. MANNER OF DEATH 1 Natural 8 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| OF 28c. INJU RY WOR | RY AT | 26d. DESCRIBE HOW | INJURY OCCURED | | | | | |
| TED 18 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify | At home, farm, atre | eet, factory, office | | 281. LOCATION (Street City or Town, State | and Number or Rur) | ral Route Number, | | | | |
| BE COMPLETED | 29a. CERTIFIER (Chack only one) 1 CERTIFYING PHY 2 MEDICAL EXAMIN | SICIAN: To the best of my knowled NER: On the bests of examination a | ige, death occurred and/or investigation, | at the time, data a | and place, and due oth occured at the | to the cause(a) and ma | nner se stated. | se(s) and manner as stated. | | | | |
| BE C | | | | | | | | | | | | |
| 101 | August 28, 1995 So. NAME AND ADDRESS OF PERSON WHO COMPLETED CANSE/OF DEATH/LITEM 27) (Type. Print) August O P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748 | | | | | | | | | | | |
| | 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGNAT | URE | 1 00., | anip spr | Ings, MD | 20 / 48 | | | | | |
| | AUG 2 9 199 | | or Revolath | | | | | A_ | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN | TO THE FUNERAL DIRECTOR: After this certific be filed within 72 hours after death with the S | IMPORTANT: If Item 28 is marked, or | |

| | | | | | | | | | | | 90 | C. | 1200 |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------|----------------|---------|------------|----------------|-----------------|-------------------|----------------------|------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1 - STATE REGISTRAR | STATE OF MA | ARYLAND / | DEPAR ERTIF | TMEN | T OF H | EALTH DEAT | AND I | MENTA | L HYGIEN REG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | 01:001 | CUEAD | | | | | | | OF DEATN | 100 | CYFAR | 3. TIME OF DEATN |
| | | Clifford | SHEAR | | | | | | Augu | ist 27 | , 195 | 13.7 | 6:45 pm M |
| | 4. SOCIAL SECURITY NUMBER | | 6. AGE (In yrs. last | | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. MIN. | 7. DATE (Mont) | OF BIRTH | | S. BIRTHP | LACE (State or Foreign |
| | 200-20-2205 | 1XXM 2 □ F | 68 | YRS. | | | | | | 26, | L927 | Penn | sylvania |
| ~ | 9a. FACILITY NAME (If not institution, give a | , | | | | | DR LOCATIO | | EATH | | | NTY OF DE | |
| Ö | 51 De Paul Str | eet | | | EI | nmits | sburg | | | | FIE | ederi | CK |
| EG | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | v | | 10c. CIT | TOWN | OR LOCAT | TON. | | | | | 1 | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s |
| DIRECTOR | | erick | | | | sburg | | | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | | | | | . ZIP CODE | | | | 40+ CITI | | AT COUNTRY? |
| H. | 51 De Paul Stre | et | | | | | 217 | | | | | U.S. | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT, | EVER IN U.S. ARC | MED | 13. | MAS DEC | | | HC OBIGIA | 7 (Specify Yes | | | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT, FORCES? 1.4. IF YES, GIVE WAI | | 10 | | If yes, sp | ecify Cubar | n, Maxica | n, Puerto I | Rican, etc.) | or No- | Black, | - American Indian, White, etc. |
| В | 3 Widowed 4 Divorced | WII, Kore | a, Vietna | m | | 1 📙 169 | 5 Muo | Specify | y: | | | Specify | White |
| ED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a. DEC | CEDENT'S | USUAL C | CCUPATIO | ON | | 16b | KIND OF BUS | INESS/INC | | |
| ET | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | | | | st of workin | g | | | | | |
| MPI | 12 | | | Sol | dier | - | | | | US Arn | ıy | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) Warren | | CITEAD | | | | | | ME (First, I | Aiddle, Maiden | | | |
| BE | | | SHEAR | | | | Em | ma | | | PUI | TERBA | AUGH |
| 2 | Duth M Class: The Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Con | | | | | | | | | | | | |
| | | | W | este | rn A | lvenu | ie, I | rwin | ı, Pe | nnsylv | rania | 156 | 542 |
| | 204_METHOD OF DISPOSITION ALABuriat 2 ☐ Cremation 3 N Rame | oval from State | 20b. PLACE A | IND DATE O | FDISPO | SITION (Na | me of | | DAT | 20c. LO | CATION — | City or Town | n, State |
| | 4 Donation 6 Other (Specify) | | Irwin | Uni | on C | emet | ery | Aug | 30 30 | ,1 995 | N. H | nting | don, Pa. |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. | NAME AN | ID ADDRES | S OF FAC | CILITY | rd P.A | | | |
| | - ruchard E | world. | MOO2 | 255 | | | | | | | | | Md. 21701 |
| | 23. PART I. Enter the diseases, or o | omplicatione that | caused the der | eth. Do n | ot ente | r the mo | de of dyle | ng, auch | h as cere | lac or reapi | ratory arr | rest, | Approximata |
| | ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final A Dose on each line) | | | | | | | | | | | | |
| | disease or condition resulting in death) | . A.S | S.C.1 | $\sqrt{\cdot}$ | D | | | | | | | | YEARS |
| | rooming in douting | W | OR AS A CONSEC | - | 7): | | | | | | | | 15/142 |
| Z | Commentative that are about | · CO | PD. | | | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (O | R AS A CONSEO | UENCE OF | 7: | | | | | | | | |
| 2 | CAUSE (Disease or injury | £ | | | | | | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO (O | OR AS A CONSEC | UENCE OF | 7): | | | | | | | | |
| 5 | | 1, | | | | | | | | | | | |
| ادّ | PART ii. Other aignificent condition | a contributing to de | eeth but not re | ecuiting I | n the u | nderiying | ceuse g | iven in I | Part i. | 24a, WAS AN | AUTOPSY | 24b. ¥ | VERE AUTOPSY FINDINGS |
| 5 | | | | | | | | | | PERFOR | | 0 | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | _ | 1 123 2 | NO | | OF DEATH? |
| 2 | DID TOBACCO USE CONTE | RIBUTE TO CAU | SE OF DEAT | TH YE | SI | NO \Box | LINC | ERTAIN | | | | ' | YES 2 NO |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL | | | E OF DEAT | | - 10 | 0110 | CIVITAII | • Ш | | | | |
| Sic | EXAMINER? | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | | 5 Rat | ridence | 6 C Other | (Snach) | | | |
| ξl | 27. MANNER OF DEATH | 28s. DATE OF IN | IJURY | 26b. TIMI | E OF | 28c. INJ1 | URY AT | | | CRIBE NOW IN | JURY OCC | CURED | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, | rear) | INJ | M M | 1 Y | RK? 'ES 2 🗌 | NO | | | | | |
| - 4 | 1 260 PLACE OF IN HIDY At home form about feature office. | | | | | | | or Rural Rou | ite Number, | | | | |
| TED | 4 Nomicide determined | Julianing, en | b. (Specify) | | | | | | City | or Town, State) | | | |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | |
| M | MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the ilms, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| | STATURE AND TITLE OF CERTIFIES | 7 | 4 | | | T | 29c. LICE | | | | | | |
| 8 | / //Ment | -cut | N | 0 | | | | | | 1 | | | 40nth, Day, Wear) 28, 1995 |
| 유 | O. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALLER | OF CHAPM OFFICE | | | | ט ט | 5164 | + | | AL | gust | 20, 1990 |

A East Frederick St., Walkersville, Md. 21793

WHO COMPLETED CAUSE OF E

Jr.,

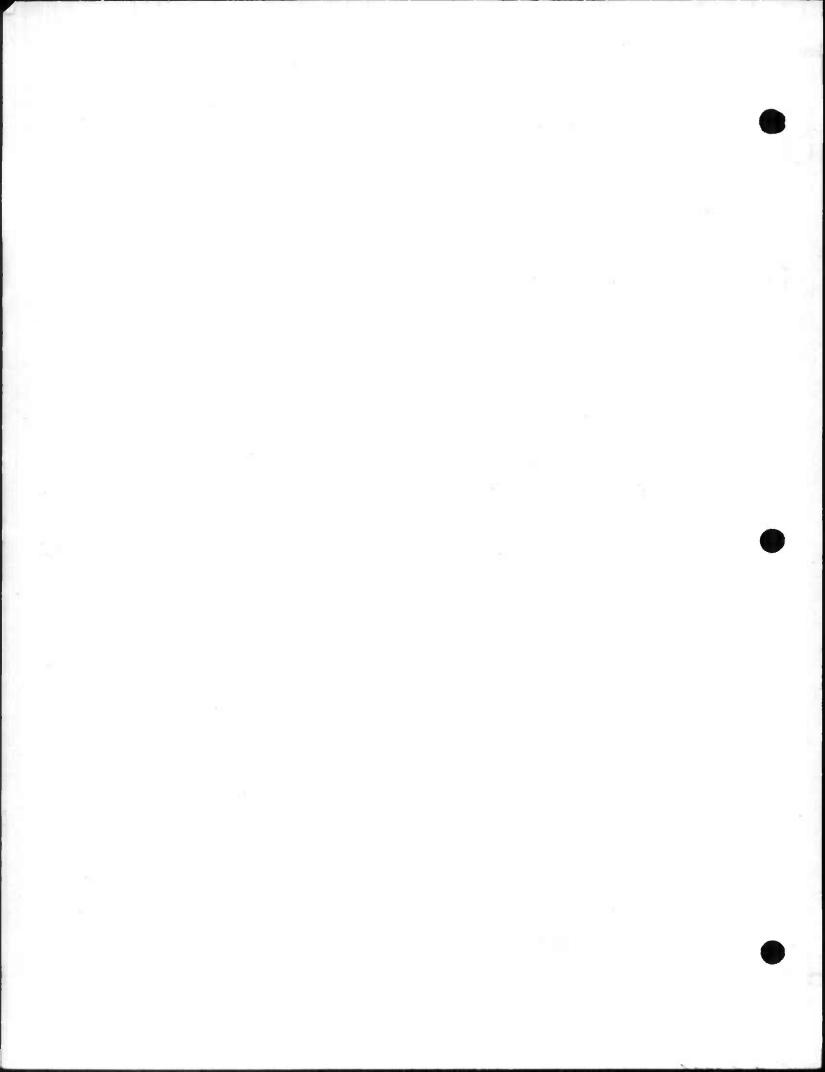
Dr. Andrew Zarick,
31. DATE FILED (Month, Day, Year)

AUG 3 0 1995

LATN (ITEM 27) (Type, Print)

31

32. REGISTRAR'S SIGNATURE
Silva Studior Radall



Page 6 may be retained by the hospital or attending physician. MARYLAND 21215-0020 BALTIMORE. ath.

permit. Pages 1, 2, 3 should

page 5 should be detached for use as the burial-transit

funeral director,

once.

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(Check only one)

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| DISCOUNT AL AL ALCONDS, P.O. BOX 80/00 | 0 | ä | Mo | <u>ē</u> |
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de- | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical exc |
| | SP | VER | Ę | 뜾 |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 ANNA LAURETTA SNYDER August 26, 10:30 A. M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH April 29, 1 M 2 F DAYS HOURS Maryland YRS. 215-32-3912 84 1911 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1709 West Seventh Street Apt 203 Frederick Frederick RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1709 West Seventh Street Apt. 203 21702 United States 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Maxican, Puerto Rican, atc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2.

IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY Specify: 3 X Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade on (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 8+) 12 Homemaker Own 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname Milton Stanley Shafer Carrie Estelle McBride BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, Stets, Zip Code) 2 Cora E. Synder 1709 West Seventh Street Frederick, MD 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☼ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State cometery, cremetory or other place)
Hagerstown Crematory 4 Donation 6 Other (Specify) 8/28/95 Hagerstown, MD 21. SIGNATURE OF FUNERAL SERVICE LIDENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, MD 21702 23. PART | Enter the diseases, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart fellure. Liet only one cause on each line. Approximate intarvai Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition___ .S.C resulting in death) years OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 VES 2 NO 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? 1 Natural 5 Pending M 1 YES 2 NO В Investigat 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281, LOCATION (Street and Number of Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide datermined 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date end place, and due to the cause(s) end manner as stated,

296. SIGNATURE AND TITLE OF CERTIFIER Maleusta

29c. LICENSE NUMBER D35164

29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Andrew Zarick, M.D. 27 E. Frederick Street Walkersville, MD

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner se stated.

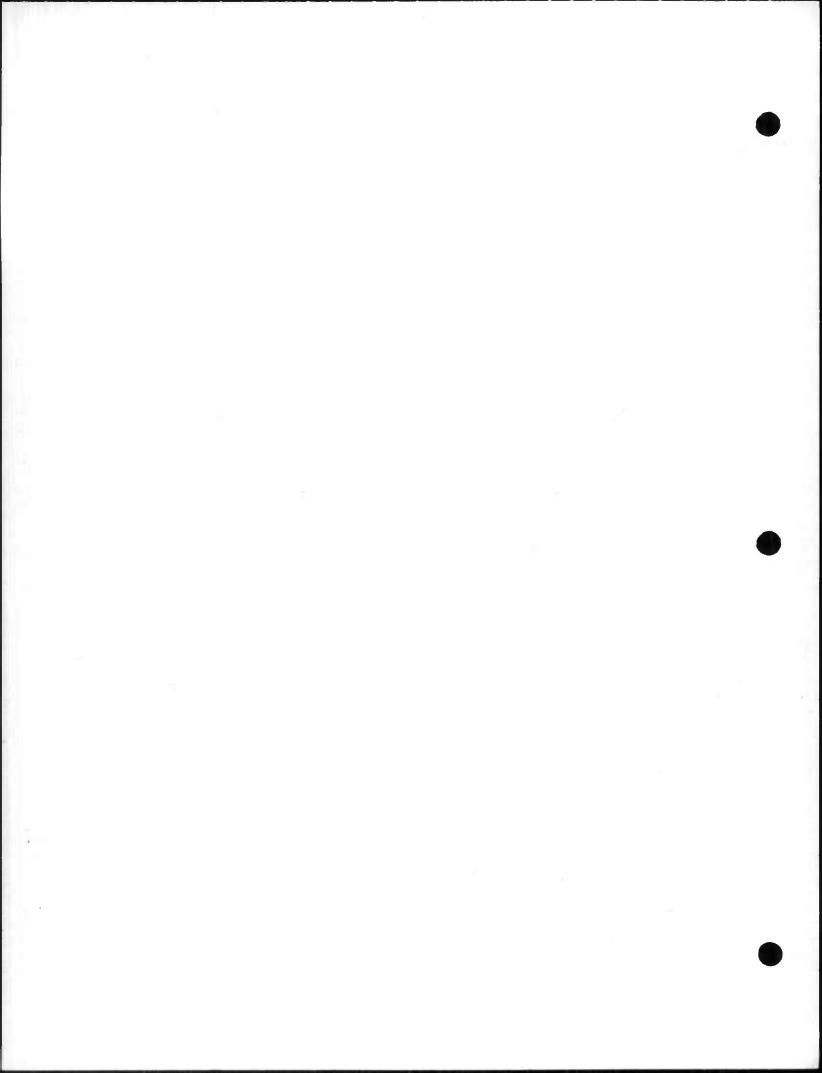
31. DATE FILED (Month, Day, Year) AUG 3 0 1995

32. REGISTRAT'S SIGNATURE

. . 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, Middle, Last) Nancy Lee Scha | mel | | | | | | | August 25 | , 199 | EAR | 2:30 P M |
|------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------|------------|--------------|---------------------------------------------------|-------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------|----------------------------------|
| Pi | | 4. SOCIAL SECURITY NUMBER 217-42-9084 | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 | YEAR DAYB | IF UNDER | 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) 10/24/43 | | BIRTHPI Country) | ACE (State or Foreign |
| . 2. 3 should | TOR | 9a. FACILITY NAME (If not Institution, give s 608 Fifth Ave.) RESIDENCE OF DECEDENT | reet and number) | | | | | Wich | | TN | Fred | OF DEA | ITN . |
| rt. Pages 1 | DIRECTOR | MD Fred | | | | TOWN OR | | | | | | | Od. INSIDE CITY LIMITS? YES 2 NO |
| 5 608 Fifth Avenue 21716 USA | | | | | | | | | | | N OF WH | WHAT COUNTRY? | |
| P 2 4 | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 N | | 113 | res, spi | ecify Cuban | F NISPANI n, Mexican Specify: | C ORIGIN? (Specify Yee, Puerto Rican, atc.) | IIGIN7 (Specify Yes or No— rio Rican, stc.) 18. RACE — America Black, White, etc. Specify: W.A. | | |
| D 21 spital or ed for u | COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 + | ·) (Gi | CEDENT'S U | retired.) | ing mo: | st of working | | Fairch | | | untnien |
| YLA by the be der | BE COM | 17. FATHER'S NAME (First, Middle, Last) James Hanold | Schamel | | | | | 18. MOTH | er's nam | E (First, Middle, Melden ine Kink | sumame) ella | | |
| E, MAR y be retained age 5 should be notified | 5 | 19a. INFORMANT'S NAME (Type/Print) John H. Handin 20a. METHOD OF DISPOSITION | ı g | 5 | 05 E | ast | "H | " St | or Rural Ac | t, Bruns | wick, | MI | |
| I IMORE . Page 6 may ral director, pa | | 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | 20b. PLACE A Permetery, cree ark | metory or other | hta. | Ce | mete | 2.ny8 | 129 Bru | CATION - CH | ck. | MD |
| death death | | | William | | | | 0 h n | Pete | PET | liams Fu ille Rd | Brun | l Ho swic | ome ck MD 217 |
| Executed within 24 hours after executed within 24 hours after to burial, cremation, or remova matic event, the medical | NO | iMMEDIATE CAUSE (Final disesse or condition resulting in death) | Interval Batween Interval Batween Onset and Death S. ARTERIUSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| th certificate be ending physician if Hygiene prior to | CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| records, requires that the death seen signed by the attern. of Health and Mental shows any injury, | MEDICAL (| PART II. Other significent condition | resulting in the underlying ceuse given in Par | | | | | 24e. WAS AN AUTOPSY PERFORMED? 246 1 YES 2 N NO | | O O | MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN? YES 2 NO | | |
| has b bept. | SICIAN: 1 | DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | TH YES | | | UNCE | ERTAIN | | | | |
| HYSICIAN: The this certificate I with the State ted, or item | PHYSIC | 1 X YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 I | INJURY | | OF 28 | g Nome | JRY AT | | Other (Specify) | NJURY OCCUP | IEO | |
| After death | ED BY | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF | F INJURY — At hor | | M | 1 🗌 Y | E\$ 2 🗌 | \rightarrow | 281. LOCATION (Street a City or Town, State) | nd Number or | Rural Rou | te Number, |
| TAL OR VAL DIRE | COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICONE) 2 MEDICAL EXAMINE | | | | | | | | | | Buse(s) e | nd manner as stated, |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | TO BE C | 296 SIGNATURE AND TITLE OF CERTIFIEF | Robert | t MD | | | | 29c LICE | NSE NUME | FD | 204 DATE 9 | GNED /A | looth Day Marsh |
| | | | COMPLETED CAUS | 15W | 774. | | F | KE. | DE | Rick . | Md | 217 | 25 1995 |
| | | SEP 0 1 199 | 32. REGISTRA | SIGNATURE | arlatte | | | | | | | | |

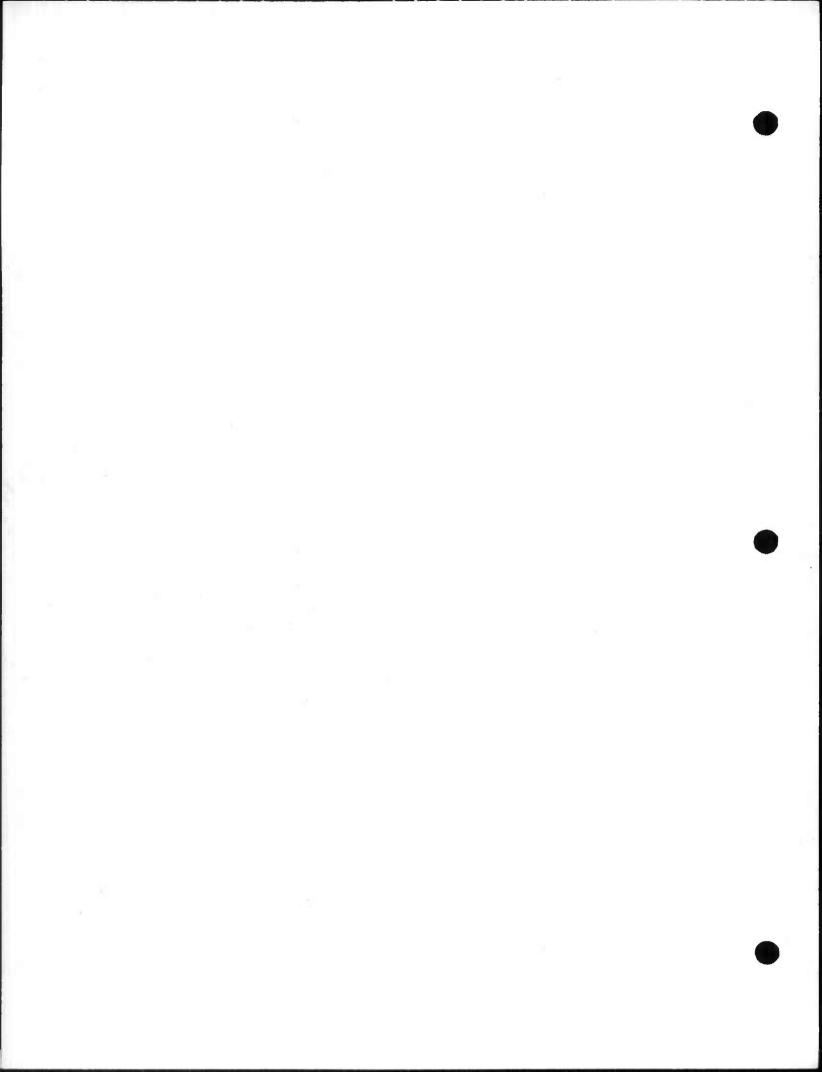


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | or more many area because the case began to the second many or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTEN | TO THE FUNERAL DIRECTOR: | IMPORTANT: If Item 28 Is |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO. | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------|---------------------|----------------------|-------------------------------------------------|---------------------|------------------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | <u> </u> | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | PATRICIA KA | THERINE | STO | GGINS | | MONTH D | , 1995 | 10:00 AH | | | | |
| | 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign | | | | |
| - 3 | 100-30-3314 | 1 🗌 M 2 🗶 F | 82 YRS. | ONTHS DAYS | HOURS MIN. | March 19, | Coun | mnsylvania | | | | |
| ~ | 9e. FACILITY NAME (If not institution, give stre | • | | Bb. CITY, TOWN C | R LOCATION OF DI | | 9c. COUNTY OF | DEATH | | | | |
| DIRECTOR | 5512 Camelot Ct | • | | Frede | erick | | Frede | Frederick | | | | |
| E C | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | | | | |
| 9 | Maryland | Frederick | | Frederi | ick | | | LIMITS? | | | | |
| AL | 10e. STREET AND NUMBER | | | 10f | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | |
| FUNERAL | 5512 Camelot | Ct. | | | 21701 | | United | States | | | | |
| 5 | | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | 13. WAS DEC | ENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No — 14. RAC | E — American Indian, | | | | |
| ВУ | t Never Married 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | | 2 NO Specifi | | Spec | | | | | |
| | 15. DECEDENT'S EDUCA | ATION | 16a. DECEDENT'S US | RUAL OCCUPATIO | M. | ter vino or nu | SINESS/INDUSTRY | WILLCE | | | | |
| COMPLETED | (Specify only highest grade of Elementary/Secondary (0-12) | ompleted) College (1-4 or 5+) | (Give kind of wo | rk done during mo: | st of working | 166. KIND OF BUS | SINE 35/INDUSTRY | | | | | |
| IP. | 12 | - | Homen | naker | | Home | | | | | | |
| ő | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTNER'S NA | ME (First, Middle, Melden | Surname) | | | | | |
| w l | Richard | Wilford Lav | ery | | Mary | y Agnes | Moyniha | an | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street en | nd Number or Rural i | Route Number, City or Town | n, State, Zip Code) | | | | | |
| | Jill Schumacher | | 5512 | Came 1 | ot Ct./ 1 | Frederick, | Maryland | 1 21701 | | | | |
| | 20a, METNOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Remov | ral from State 20b. | PLACE AND DATE OF | DISPOSITION (Na | me of | | CATION — City or To | | | | | |
| , | 4 Donation 5 Other (Specify) | | OAKLAND (| | | | rren, Per | nnsylvania | | | | |
| ĺ | 21. SIGNATURE OF FUNERAL SERVICE LICE | NOSEE / | | 22. NAME AN | D ADDRESS OF FA | Stauffe | er Funera | al Home | | | | |
| | L'aymond 5 | elerson | | 1621 (| possumt | own Pike/Fi | rederick | Md. 21702 | | | | |
| | 23. PART i. Enter the diseeses, or co | mplications that caused ist only one cause on ea | the death. Do not | enter the mod | de of dying, auc | h as cardiac or respi | ratory arrest, | Approximate interval Batween | | | | |
| | IMMEDIATE CAUSE (Final | 4 | | | | | | Onset and Death | | | | |
| | disease or condition a. Cor pulnonale lyes | | | | | | | | | | | |
| | disease or condition and resulting in desth) a. Due to (or as a confecuence of): Due to (or as a confecuence of): Sequentially list conditions, if smy, leading to immediate of the confecuence of): Due to (or as a confecuence of): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, b. | DUE TO (OR AS A | CONSEQUENCE OF: | ruce | eve pr | Umstra | eg Alsea | a/5 years | | | | |
| Ä | if any, isading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| Ĕ | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| FR | resulting in death) LAST | | | | | | | | | | | |
| | PART ii. Other significent conditions | contributing to death be | ut not resulting in | the underlying | Cettee alven in | Part I. 24s. WAS AN | AUTOBRY 244 | . WERE AUTOPSY FINDINGS | | | | |
| CAL | Huperton | 10100 | Zerrei | | Couse given in | PERFOR | | AMILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| | - I vascul | 20 11 | | unay | | 1 NES 2 | ZNO | OF DEATH? | | | | |
| ≥ | DID TOBACCO USE CONTRI | | EDEATH YES | I4 110 I | UNCERTAIN | <u></u> | | 1 NES 2 NO | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 8. PLACE OF DEATN | | OTTOLICIAN | 101 | | | | | | |
| Sic | | HOSPITAL: 1 Inpetient 2 ER/Outpe | etlent 3 DOA 4 | THER: | 5 Amesidence | 8 Other (Specify) | | | | | | |
| Ě | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| OF 28c. INJU | JRY AT | 28d. DESCRIBE NOW IP | JURY OCCURED | | | | | |
| BY | t Natural 5 Pending 2 Accident Investigation | (momi, buy, rour) | *************************************** | | ES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Speci | — At home, farm, stre | et, factory, office | | 281. LOCATION (Street a City or Town, Stete) | nd Number or Rural | Route Number, | | | | |
| | 4 Nomicide determined | | | | | | | | | | | |
| Soliding and Number of Rural Route Number, attention, street, factory, ornce 291. LOCATION (Street and Number or Rural Route Number, attention). Street and Number or Rural Route Number, attention, street, factory, ornce 292. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) and menner ee stated. | | | | | | | | | | | | |
| ğ | One) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and menner ee stated. | | | | | | | | | | | |
| BE (| 296. SIGNATURE AND TIME OF CENTIFIER | 7/1/ | 1.64 | 5 | 29c. LICENSE NUN | IBER | 29d, DATE SIGNED | (Month, Day, Year) | | | | |
| 0 | (Max | 10/10 | Julie | DIE | D-3518 | 3 | 18/ | 25/95 | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO | 0 | | | | | | | | | | |
| | Afrookteh, Ali Jan 31. DATE FILED (Month, Day, Year) | mes, M.D. 30 | U West Ni | inth Str | reet, Fre | ederick, M | 21701 | | | | | |
| | AUG 3 0 199! | 32. REGISTRAT'S HOME | Jun P. C. | Ñ | | | | | | | | |
| | 1150 0 133 | g | and actually | | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal:

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE STATE CERTIFICATE OF DEATH STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------|-------------------------------------------------|---------------|----------------------------------------|-------------------------------|---------------------------|-------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | ANDERS | | | | | 2. DATE OF DEATH | AY | YEAR 25 | 3. TIME OF DEATH 8 49 P M | |
| | The contract of the second | 5. SEX 6. AGE | (In yrs. last birthday) | MONTHS C | EAR IF UNDER | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | Countr | ** | |
| | 9a. FACILITY NAME (If not institution, give stree | A 22 | 71 1113. | 9b. CITY, T | OWN OR LOCATI | | 9JANUARY_ | 24 1 | | TYSBURG, PA. | |
| OR | ST. CATHERINE'S NO | JRSING HOME | | | SBURG | | | FREI | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CI | TY, TOWN OR | | | | 10d, INSIDE CITY | | | |
| DIR | MARYLAND FREDER | RICK | EM | MITSBU | IRG | | | LIMITS? | | | |
| 3AL | 10e. STREET AND NUMBER | | | | 10f. ZIP COD | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 711 W. MAIN ST. | 2. WAS DECEDENT EVER I | NIIS ADMEO | 49 148 | | 21727 | ORIGIN? (Specify Yes | | S. | | |
| | 1 Never Married 2 X Married | FORCES? 1 YES | 2 X NO | If y | s DECENDENT (se, specify Cubi YES 2 X NO | ın, Maxican, | Puerto Rican, etc.) | or No.— 1 | 4. RACE Black Spec/ | American Indian, c, White, etc. | |
| D BY | 3 Widowed 4 Divorced | | | | | | | | | " WHITE | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co. | mpleted) College (1-4 or 5+) | 18a. OECEDENT'S (Give kind of life. Do NOT u | work done dun | JPATION ng most of worki | ng | 16b. KIND OF BUS | SINESS/INOUS | STRY | | |
| MPL | 8 | Conege (I-4 or 5+) | SEAMST | RESS | | | DRESS | FACTO | ORY | | |
| CO | 17. FATHER'S NAME (First, Middle, Last) | | 11 | | 18. MOT | HER'S NAME | (First, Middle, Maiden | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | KECKLER | 19h MAII ING | Annerss /s | treat and Number | or Primi Box | EDDA ute Number, City or Town | MORT | (- d-1 | | |
| 우 | JASON E. SANDERS | 5 | | | | | SBURG, MD | | | | |
| | 20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remove | 200 | PLACE AND DATE | OF DISPOSITION | | | | CATION — CH | | wn, State | |
| | 4 Donation 5 Other (Specify) | El El | MMLITSBU | RG MEN | ORIAL ME AND AGORE | 8/25 | | ITSBU | RG. | MD. 21727 | |
| | · John m | . Skile | 1 | | | | SKILE: | | | | |
| | 23. PARY I. Enter the diseases, or con ahock, or heart fellure. Lis | nplications that cause | d the deeth. Do | not enter th | e mode of dy | Ing, auch | aa cardlec or reapi | ratory arrea | it, | Approximate Interval Between | |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) • Use TO (or AS A CONSEQUENCE OF): • Use TO (or AS A CONSEQUENCE OF): | | | | | | | | | | |
| _ | | OUE TO (OR AS A | CONCEOUENCE | 4 A A A | Fr | 1 At | -0.100 | + | | 5 24. | |
| TIO | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE O | F): | di. | 1 / | 1. | 1 | 1 1 | 1 | |
| I CA | CAUSE (Disease or Injury | maul | - 120 | Alv | den | X | Fralie | tes | rel | litus year | |
| ERTIFICATION | that initiated events resulting in death) LAST | Cerchion | rascula | n a | ccid | ent | E Hem | ipai | i | 2 8 mo | |
| CE | PART II. Other significent conditions | contributing to death b | ut not resulting | in the unde | rlying cause | niven in Pe | art I. 24a. WAS AN | ALITOREY | Lan | WERE AUTOPSY FINDINGS | |
| ICA | Hypertensian | Consest | | out F | ailu | 1 | PERFOR | MED? | 240. | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| MEDIC | Ostoporosis | with ~ | nultin | ul | actu | es | 1 TYES 2 | X NO | | OF DEATH? | |
| ä | DID TOBACCO USE CONTRIE | | | ES 🗆 🖟 | | ERTAIN | | | | | |
| PHYSICIAN: | | OSPITAL: | 26. PLACE OF DEA | OTHER: | | V-SIP | | | | | |
| HA | 27. MANNER OF DEATH | 28s. DATE OF INJURY | 28b. TW | E OF 26 | c. INJURY AT | _ | Other (Specify) 8d. OESCRIBE HOW IF | NJURY OCCU | RED | | |
| ВУ Р | 1 X Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | M ; | WORKT | NO | | | | | |
| COMPLETED | 3 Suicide & Could not be 4 Homicide determined | 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Chica Form State | | | | | | | Aural A | oute Number, | |
| IPLE | 29a. CERTIFIER (Check only | | | | | | | | | | |
| CON | one) 2 MEDICAL EXAMINER: (| On the basis of examination | and/or investigation | on, in my opin | on, death occur | ed at the tin | ne, data and place, and | d due to the | cause(a) | and manner as stated. | |
| TO BE | 296. SIGNATURE AND TUTLE OF CERTIFIER | Com | all | MN | 29c. JCI | 187 | 05 | 29d. DATE S | 12 | (Month, Day, Year) 2195 | |
| - | ALAN CARROLL, M. | D SOUTH | SETON A | AVF. F | MMITSBI | JRG. N | MD. 21727 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRARIS SIGN | ATURE | | | | | | | | |
| | AUG 2 5 1995 | Java willed | TOTAL PORT | 1 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

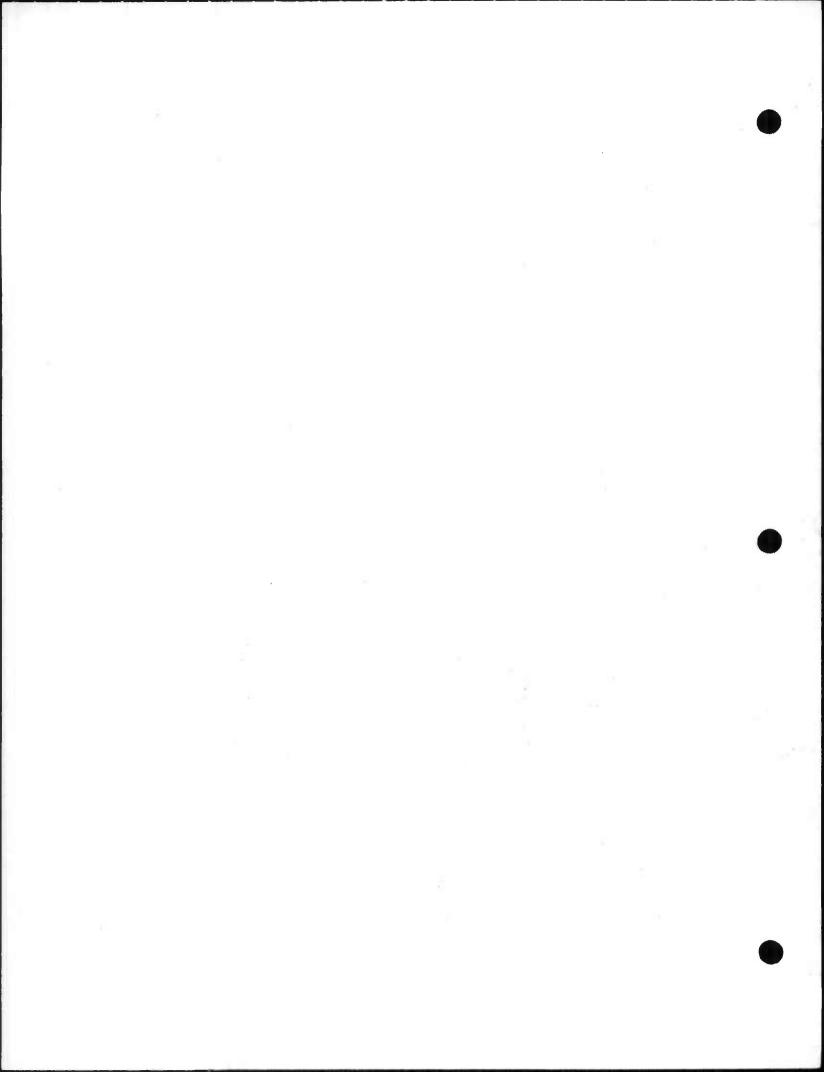
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

| STATE 0 | F MARYLAND / DEPARTMENT | OF HEALTH AND | MENTAL | HYGIENE |
|---------|-------------------------|---------------|--------|----------|
| AR | CERTIFICATE | OF DEATH | | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MA | RYLAND / DEPA CERTI | RTMEN | T OF H | EALTH | AND I | MENTA | L HYGIEN | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------|----------------------------------------------|---------------------------------------------|------------------|-------------------|-----------|------------------|----------------------------------|-------------|------------------------------------------------------|-------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | OF DEATH | | | 3. TIME OF DEATH | |
| | FRANCES | | SNYDER | | | | | AUG | UST 19 | AY 1. 19 | YEAR 195 | 10.00P M | |
| | 4. SOCIAL SECURITY NUMBER 577-58-7611 | | AGE (In yrs. lest birthde | AACAFTUR | DAYS | IF UNDER | 24 HRS. | 7. DATE (Mont | OF BIRTH h, Day, Year) 29, | | 8. BIRTHPLACE (State or Foreign Country) 1904 Kansas | | |
| | 90. FACILITY NAME (If not inetitution, give et | 1 M 2 X F | 90 YRS. | 1 | | | | | . 29, | 1904 | | | |
| E | Prince George's 1 | r, town o lever | R LOCATIO | ON OF DE | EATH | | | INTY OF C | | | | | |
| OLO | RESIDENCE OF DECEDENT | | | Ci | evet | ту | | Prince Georg | | | | George's | |
| IRE | 10a. STATE 10b. COUNTY | | ITY, TOWN | OR LOCAT | ION | | | | | | 10d, INSIDE CITY LIMITS? | | |
| LD | Virginia Arlii | No | ne | | | | | | | | 1 YES 2 NO | | |
| FUNERAL DIRECTOR | 2113 N. Gleebe Rd | | | | | 2207 | | | | | | States | |
| UNE | 11. MARITAL STATUS | 12. WAS DECEDENT E | VER IN U.S. ARMED | 13. | | | F HISPAN | IIC ORIGIN | 17 (Specify Yes | | , | | |
| BY F | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 [] | | | If yes, sp | | | n, Puerto i | Rican, atc.) | | | E — American Indian, k, White, atc. | |
| | | and the second | | } | | | | | | | Wh | îte | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 16a. DECEDENT (Give kind o | 'S USUAL O If work done use retired.) | during mo. | N It of workin | g | 18b | KIND OF BUS | SINESS/IN | DUSTRY | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | Dept. | | | 20 | | | overme | n+ | | - 1 | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | 21 | Dept. | 01 00 | mmer | | ER'S NA | | Widdle, Maiden | | | | |
| BE C | Charles James Snyo | der | | | | | | | Thomas | | | | |
| TO B | 19e. INFDRMANT'S NAME (Type/Print) | | 19b. MAILH | G A CORES | S (Street e | | | | ber, City or Town | | p Code) | | |
| - | Frances Catterton | | 1232 | 5 Mel | ling | Ln. | Bow | vie, | MD. 20 | | | | |
| | 20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo | wal from State | 20b. PLACE AND DAT cemetery, premetery pr | e OF DISPOS | SITION (Na | ne of | | DAT | | | City or To | | |
| | 4 Donation 8 Other (Specify) | ENGEE | National | | | Par. | | | 3 Fal | IS C | nurc | h, VA. | |
| | | me | 0 | | | | | A | | | | al Home. VA. 22203 | |
| | 23. PART I. Enter the diseases, or co | omplications that co | used the death. Do | | | | | | | | | Approximata | |
| | ahock, or heart fallure. L IMMEDIATE CAUSE (Final | lat only one cause | on each line. | | | | | | | | | Interval Between Onast and Death | |
| | disease or condition resulting in death) | 25 | (01 | C | | | | | | 4urtse | | | |
| | Sequentially list conditions. | | | | | | | | | | 1 | | |
| ON | Sequentially list conditions, | DUE TO KOR | as a compromence | - P | eci | al | Ch | nc | 21 | | | 1-2 years | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | | | orj. | | | | | | | | | |
| Ĕ | CAUSE (Diseese or Injury that Initiated events | DUE TO (DR | AS A CONSEDUENCE | OF): | | | | | | | | | |
| ERI | resulting in death) LAST | | | | | | | | | | | 1 | |
| AL C | PART II. Other algnificant conditions | contributing to dea | nth but not regulting | In the un | derivino | ceuse a | iven in i | Part I. | 24s. WAS AN | AUTOPSV | 24h | WERE AUTOPSY FINDINGS | |
| SA | Atral | Fiber 1 | alion . | | , | | | | PERFOR | MED? | 1 | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | 1200 | | | | | | _ | 1 TYES 2 | NO | | OF DEATH? | |
| ž | DID TOBACCO USE CONTR | IBUTE TO CAUS | E OF DEATH Y | ES 🗆 I | NO 🗖 | UNC | ERTAIN | 10 | | | | T TES 2 NO | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE DF DE | ATH (Check | only one) | | | | | | | | |
| YSI | 1 TYES 2 ND | HOSPITAL: | VOutpatient 3 □ DOA | 4 Nun | | 5 🗆 Rec | eldence | 6 🗆 Other | (Specify) | | | | |
| H H | 27. MANNER DF OEATH 1 Natural 5 Pending | 28e. OATE OF INJ (Month, Day,) | | ME OF | 28c. INJU WOI | | | 28d. DES | CRIBE HOW IN | JURY OC | CURED | | |
| BY | 2 Accident Investigation | 20. 21.02.02.02 | | M | | ES 2 _ | NO | | | | | | |
| | | | | | | | | or Rural F | loute Number, | | | | |
| 3 Suicide 4 Homicide 8 Could not be determined building, etc. (Specify) 298. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 298. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. | | | | | | | | | | | | | |
| 8 | | : On the basis of exami | nation end/or investigat | lon, in my o | pinion, de | | | | end place, end | d due to th | ne Ceuse(e |) end manner ee stated. | |
| H | 296. SIGNATURE AND TITLE OF CERTIFIER | 910 | Toni. | | | 29c. LICE | NSE NUM | BER | 4 | 29d. DAT | E SIGNED | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE O | F DEATH (ITEM 27) (367 | e. Print1 | | 2 | 7 | 41 | 7 | 8 | 1 | 10-75 | |
| | Sam Tella | wi 4 | m coo | | che | elle | الأد | e. | Ru. | R | SW | e, mD | |
| | AUG 24 1995 | 32 REGISTRAR'S | COGNAL URE | | | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | | | | | | | | | | | | 6-16-1 | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------|--------------|--------------|----------------|---------------------|-----------|----------------|-------------------------|-------------|--------------|--------------------|--------|
| | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR | TMEN | T OF H | EALTH DEAT | AND I | MENTAL | HYGIEN REG. NO | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | F DEATH | | | 3. TIME OF DEA | ТН |
| | BERKLEY | CLAYTON | SW | EET | | | | | Augus | st 18 | . 199 | 95 | 12:45 | PM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le: | st birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | BIRTH | , | 77 | HPLACE (State or F | |
| | 278-26-4355 | 1 🔀 M 2 🗆 F | 70 | YRS. | MONTHS | DAYS | HOURS | MIN. | June (Month, I | Day, Year) | 1025 | Ohi | | |
| | 9e. FACILITY NAME (If not institution, give s | treet and number) | | | 9b, CIT | Y. TOWN C | R LOCATIO | N OF DE | | 11, | | | NTY OF DEATH | |
| Œ | 7508 Ben Avon Roa | hd | | | | Beth | | | | | | ontgo | | |
| I K I | RESIDENCE OF DECEDENT | | | | | Decin | ssua | | - | | IMIC | Jircyc | Jiliet y | |
| DIRECTOR | 10s. STATE 10b. COUNT | Υ | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CIT | ٧ |
| | Maryland N | 1ontgomer | У | | | Beth | esda | | | | | | LIMITS? | (NO |
| AL AL | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | | 10g. CIT | IZEN OF | WHAT COUNTRY? | |
| 띪 | 7508 Ben Avon Roa | nd | | | | | 208 | 17 | | | Un | ited | States | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AF | MED | 13. | WAS DEC | ENDENT OF | F HISPAN | IIC ORIGIN? | Specify Ye | s or No- | 14. RAC | E — American Ind | en, |
| BY F | 1 Never Married 2 Merried | IF YES, GIVE W | MR OR DATES | NO | | If yes, spe | 2 NO | Specify | n, Puerto Ric | en, atc.) | | Spec | k, White, etc. | |
| | 3 Widowed 4 Divorced | WW II | | | | | | | | | | | "White | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | /G | CEDENT'S | work done | during mo- | ON st of working | a | 16b. K | IND OF BU | SINESS/IN | DUSTRY | | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 8 + |) ///o | . Do NOT u | se retired.) | | | | _ | | _ | | | |
| ₩ E | 12 | | Pre | eside | nt | | | | Tr | ade / | Assoc | iati | on | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | 0 | | | | | 16. MOTH | | ME (First, Mid | | | | | |
| H | Clayto | n Swe | | | | | | | orett | | | | | |
| 6 | 19a. INFORMANT'S NAME (Type/Print) | 4 | | | | | | | Toute Number, | | | p Code) | | |
| - | Joyce Sweet | (Wife) | | 7508 | Ben | Avon | Rd. | Be | thesd | a, MI | 20 | 817 | | |
| | 20e. METHOD OF DISPOSITION 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Rem | oval from State | 20b. PLACE | ANDDATE | OF DISPO | SITION (Na | me of | | | | CATION - | City or To | own, Sizte | |
| | 4 Donation 8 Other (Specify) | | Ches a | apeak | e Cr | emat | ory | | 8-19 | Be ' | ltsvi | 11e, | MD | -6.3 |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | | D ADDRES | | | 000 | D | Λ | | |
| | (en Arily | herton | | | | | | | Servi | | | | , MD 209 | 10 |
| | 23. PART i. Enter the diseases, or o | complications that | caused the de | ath. Do r | not ente | the mo | de of dvir | AVEI | nue, S | C OL LESID | Iratory ar | TITIU | Approxim | |
| | shock, or heert fellure. | List only one cau | se on each line |). | | | 0 | | | | | 1001, | Interval B | etween |
| | iMMEDIATE CAUSE (Final disease or condition | MAO | tasta | ti | (1) | 2 | .// (| 0// | 1 C | M / / A | 1 1 | | Onset an | |
| | resulting in death) | a. DUE TO | OR AS A CONSE | DUENCE O | PI: | NU | y y | 211 | · Ce | M | | | pour | 200. |
| _ | _ | | | A10104 | ,- | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | b | OR AS A CONSE | DUENCE OF | F): | | | | | | - | | | |
| M | cause. Enter UNDERLYING | | | | | | | | | | | | | |
| Ĕ | CAUSE (Disease or injury that initiated events | DUE TO | OR AS A CONSE | DUENCE O | F): | | | | | | | | 1 | |
| 본 | resulting in death) LAST | d. | | | | | | | | | | | | |
| ö | DART II ON A LINE III | | | | | | | | | | | | | |
| K | PART ii. Other algnificant condition | a contributing to | deeth but not a | esulting | in the u | nderlying | ceuse gi | iven in I | Pert i. 2 | PERFO | | 24b | WERE AUTOPSY F | |
| MEDICAL | | | | | | | | | _ 1 | YES 2 | NO NO | | OF DEATH? | CAUSE |
| ¥ | | | | | | | | | _ | | | | 1 🗌 YES 2 💢 | NO |
| SICIAN: | DID TOBACCO USE CONTI | RIBUTE TO CA | USE OF DEA | TH YE | S | NO 🗆 | UNCE | ERTAIN | 1 🗆 | | | | | |
| CA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | E OF DEAT | | | | | | | | | | |
| \SI | 1 TYES 2 NO | 1 Inpatient 2 | ER/Outpatient 3 | □ DOA | 4 Nu | R: sing Hom | 5 X Res | idence (| 6 🗆 Other (S | Specify) | | | | |
| РНУ | 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | | |
| ВУ | 1 Naturel 5 Pending 2 Accident Investigation | 44.7 | entre. | | М | | ES 2 🗌 | NO | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE Of building, | F INJURY - At ho | me, ferm, | street, fec | tory, office | , | | 28f. LOCATI | ON (Street lown, State) | and Number | r or Rural F | Route Number, | |
| ETED. | 4 Homicide determined | | | | | | | | , or | | | | | |
| 7 | 290. CERTIFIER (Check only | CIAN: To the best of | my knowledge, de | ath occurr | d at the i | lime, dete | and place. | end due | to the cause | (s) end me | nner ea ste | ted. | | |
| COMPL | one) 2 MEDICAL EXAMINE | | | | | | | | | | | |) end manner ea s | tated. |
| | 29b. SIGNATURE AND TITLE OF CENTURIES | | | | | 1 | 29c. LICEN | | | | | | | |
| BE | THE | 2 | | | | | 17 | 20 | 97 | | | | (Month, Day, Year) | ,,, |
| 2 | 30. NAME AND ADDITION OF PERSON WH | O COMPLETED ONLE | F OF DEATH #7 | | | | 172 | Joh | 1 | | LA | ugus | t 18, 19 | 175 |

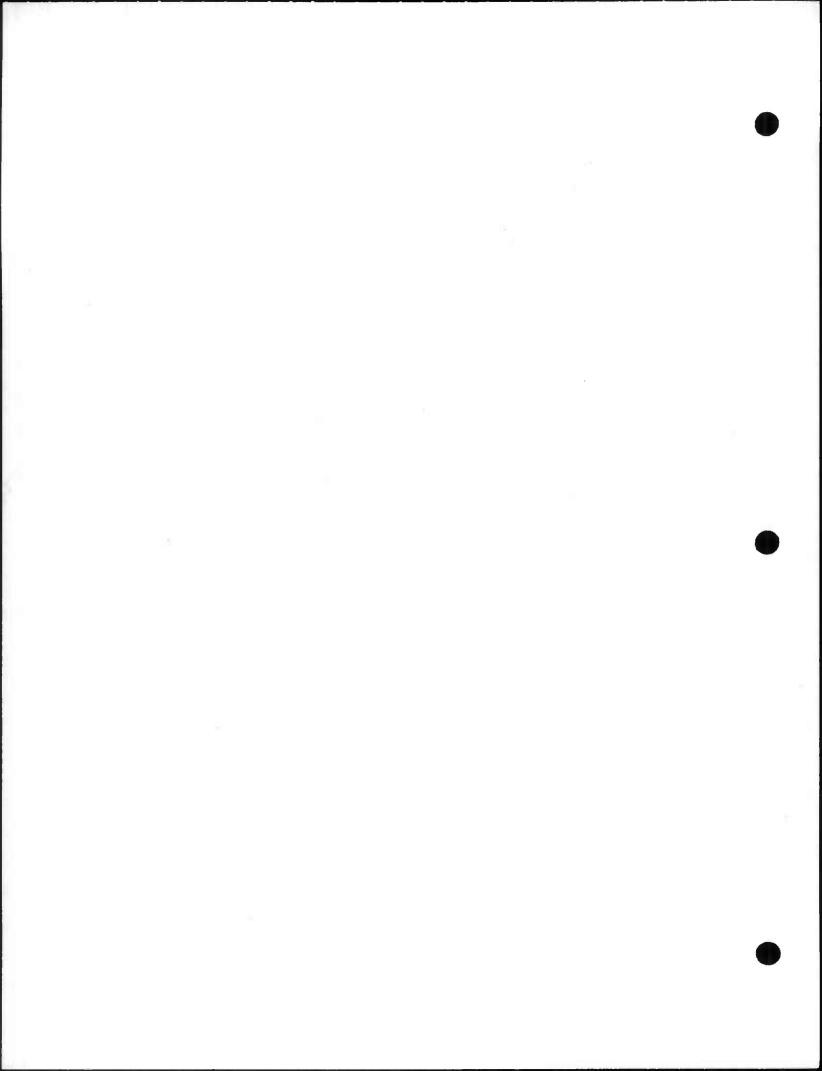
Washington, DC 20015

Frederick P. Smith, MD

31. DATE FILED Month, Day, Year,

AUG 21 1995 MD 5401 Western Ave., NW 22. REGISTRAR'S SIGNATURE

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



| 09289 |
|--------|
| BOX |
| P.0. |
| ORDS, |
| RECORI |
| VITAL |
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| 2 |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

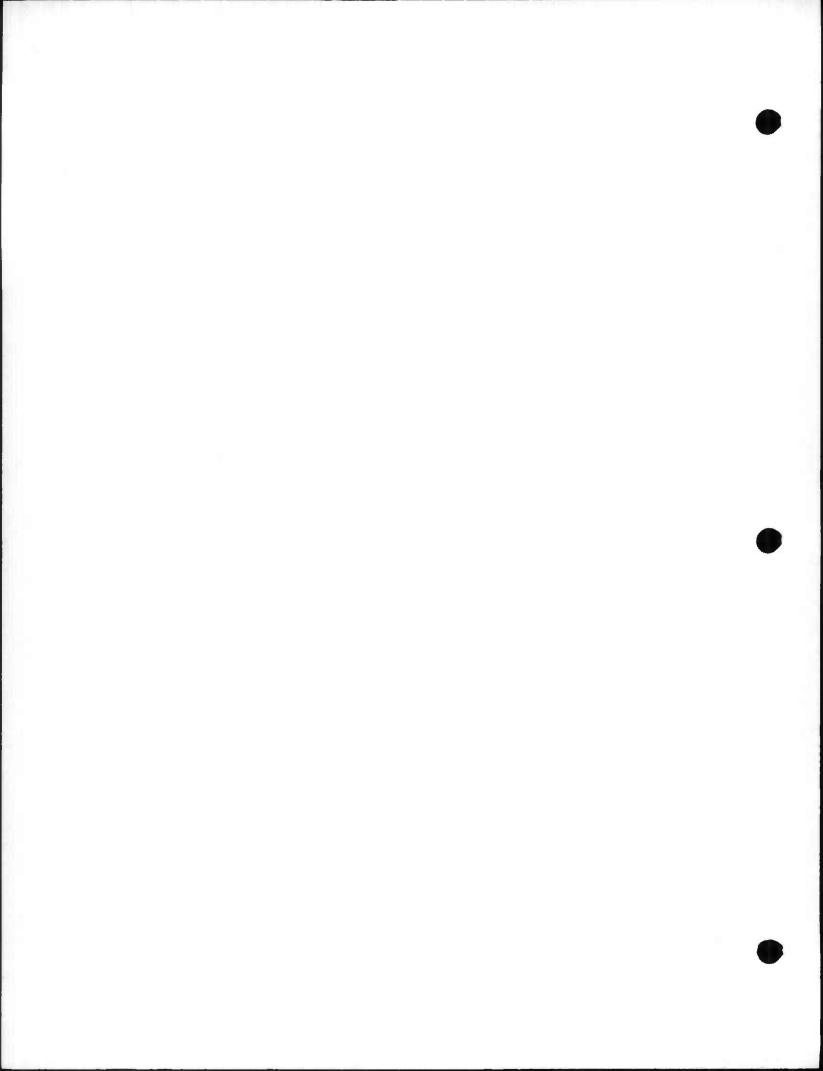
| | FOR 1 - STATE REGISTRAR | STATE OF MARY | | | | EALTH AND | MENTA | L HYGIEN | E | | |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------|---------------|----------------------|---------------------|---------------------------------------------------------------------------|------------------|------------|------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | E OF DEATH | | / | 3. TIME OF DEATH |
| | Alma B. | Schae | ffer | | | | MON | 8/1 | 519 | SYEAR | 4.00A " |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER | DAYS | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | 6. BIRTI | IPLACE (State or Foreign |
| | 213-74-2762 | 1 M 2 X F | 95 YRS. | | | 100 | Jun | e 6, 1 | 900 | | ington, D.C. |
| oc | 9a. FACILITY NAME (If not institution, give str | | | | | R LOCATION OF D | EATH | | | UNTY OF E | |
| DIRECTOR | Bedford Court Nur | sing Home | | 51 | Lver | Spring | | | Мо | ntgo | mery |
| 3EC | 10e. STATE 10b. COUNTY | | 10c. Cf | TY, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY |
| | | omery | | Silv | er S | pring | | | | | 1 TES 27 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | | 1 - 1 - 1 | | WHAT COUNTRY? | |
| NE | 1400 Harding Lane | | | | | 20905 | | | | USA | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 NO | | If yes, sp | ENDENT OF HISPA | an, Puarto | | or No- | 14. RACI Blac | E — American Indian, k, Whita, atc. |
| 8 | 3 Nidowed 4 Divorced | IF YES, GIVE WAR OR | DATES | | 1 YES | 2X NO Specif | fy: | | | Spec | my: White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | | 16a. DECEDENT'S | S USUAL O | CCUPATIO | IN at of working | 18 | b. KIND OF BU | BINESS/IN | IDUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 8 +) | Ille. Do NOT | use retired.) | | at or warrang | N | 1 11 | | | 4 |
| MP | 17. FATHER'S NAME (First, Middle, Last) | 0 | 56 | cret | ary | | | aval W | | | |
| | H. Albert Buehler | | | | | Emilie | | | Sumame) | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILIN | G ADDRES | S /Street a | | | | n State 7 | 'in Code) | |
| 10 | Patricia B. Patton | L | | | | | Aoute Number, City or Town, Stete, Zip Code) 1ver Spring, Maryland 20905 | | | | |
| | 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City of Town, State | | | | | | | | | | |
| | Fort Lincoln Cemetery 8/18 Brentwood, Maryland | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | DISEE / 1-0/ | 1 | | | New Ham | | | | di F | uneral Home |
| | Janu . | 14000 | ma | | | r Spring | | | | 904 | |
| | 23. PART i. Enter the disesses, or co shock, or heart failure. L | omplications that ceus | ed the death. Do | not sate | the mo | da of dying, suc | ch se car | diec or respi | ratory as | rreat, | Approximats interval Batween |
| | IMMEDIATE CAUSE (Final | 1 | | . / | 12 | | M | , | | | Onset and Death |
| | disease or condition resulting in death) | gestiv | () | acc | conty, | pari | y | 10 years | | | |
| _ | | DUE TO FOR AS | A CONSEQUENCE (| ori: | 1 200 | rell | steen | 10,000 | | | |
| ō. | disease or condition resulting in death) DUE TO JOR AS (CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or conditions) DUE TO JOR AS A CONSEQUENCE OF): | | | | | | | | | | 10 gene |
| 8 | | | | | | | | | | | |
| E | that initiated events | DUE TO (OR AS | A CONSEQUENCE (| OF): | | | | | | | |
| CERTIFICATION | d | | | | | | | | | | |
| A | PART II. Other significant conditions | contributing to death | but not resulting | In the ur | nderlying | csuse given in | Part i. | 24a. WAS AN | | 24b | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| PHYSICIAN: MEDIC | | | | | | | | 1 TES 2 | No | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | 1 - YES 2 - NO |
| Ä | DID TOBACCO USE CONTR | IBUTE TO CAUSE (| | | | UNCERTAI | N | | | | |
| SC | | HOSPITAL: | 26. PLACE OF DEA | OTHE | A: | | | | | | |
| ¥ | 27. MANNER OF DEATH | 1 ☐ Inpatient 2 ☐ ER/Ou 28e. DATE OF INJURY | 26b, Til | | sing Hom 28c. INJ | 5 Residence | | SCRIBE HOW II | HIDV O | CHRED | |
| | 1 Netural 5 Pending | (Month, Day, Year) | | JURY | WO | | 200.00 | younge How ii | 100MT 00 | JOUNED | |
| D BY | 3 Suicide 8 Could not be | 28a. PLACE OF INJUR building, etc. (Spi | Y — At home, farm, | street, fac | tory, office | | 28f, LOC | CATION (Street a | nd Numbe | or Or Rural F | Toute Number, |
| COMPLETED | 4 Homicide detarmined | | | | | | City | or Town, State) | | | |
| PLE | 29a. CERTIFIER 1 CERTIFYING PHYSIC | IAN: To the best of my know | wiedge, daath occur | red at the t | ime, data | and place, and due | to the ca | use(s) and man | ner aa ste | rted. | |
| S | one) 2 MEDICAL EXAMINER | On the basis of examinati | on and/or investigati | on, in my o | pinlon, d | eath occured at the | time, data | a end placa, an | d due to t | the cause(s |) and manner as stated. |
| 8 | 296. SIGNATURE AND TITLE GEOERTIFIER | iò. | | | | DZ/9c LICENSE NUI | MBER | | 29d. DA | . / / | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF D | EATH (ITEM 27) (Type | o, Print) | , 5 | live for | VIII. | MAN | 1280) | 6 | |
| | | | | 01.07 | 0 1 | V/ | | 1.726 | ,., 0 | | |
| | AUG 21 1995 | Julia Davides | ~ Rardall | | | | | | | | |



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| P.O. | |
| RECORDS, I | |
| OF VITAL | |
| DIVISION | |
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| | d for use as the burial-transit permit. Pages 1-2-3 shi | |
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| Shysic | burial | |
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| ay be | page | |
| E 9 | octor, | |
| Page | al dire | |
| leath. | funer | |
| after c | y the | removal. |
| 24 hours after death. Page 6 may be retain | d in t | or re |
| | y file | rtion. |
| SICIAN; The law requires that the death certificate be executed within | pletel | Crema |
| cuted | T COT | unial. |
| 900 | In an | prior to burial. |
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| PITAL | SAL O | in 72 ho |
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| | | 1 - FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEPAR CERTIF | RTMENT OF | HEALTH AND N | NENTAL HYGIEN | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATN DAY YEAR 3. TIME OF DEATN | | | |
| | | Charles K. STOK | | | | | 8/ | 7/95 | 1,50% | | |
| P | | 4. SOCIAL SECURITY NUMBER 216-44-9557 | 1 🔀 M 2 🗌 F | GE (In yrs. last birthday) 80 YRS. | IF UNDER 1 YEAR | | 7. DATE OF BIRTH (Month, Day, Year) Feb 20,] | L915 Te | OTHPLACE (State or Foreign intry) Ennessee | | |
| 2, 3 should | <u></u> | 86. FACILITY NAME (If not institution, given | | | | N OR LOCATION OF DEA | | | | | |
| 1, 2, 3 | DIRECTOR | 1300 Mill Grove | | | Si | lver Sprin | ng | Montgo | omery | | |
| Pages 1, | I H | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY | | |
| F. | | | tgomery | gomery Silver Spring | | | | | 1 YES 2 NO | | |
| It pen | ₽ ₩ | 1300 Mill Grove | D1 000 | | | 19g. CITIZEN OF WHAT COUNTR | | | | | |
| 020 physician, burial-transit permit. | FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVI | ED IN 11 C ADMED | 40 1100 5 | 20905 | | USA | | | |
| 6-0020 ding physic the burial | B | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 X Y IF YES, GIVE WAR O WW II | ES 2 NO | If yes, | BECENDENT OF NISPANI specify Cuben, Mexican (ES 2 NO Specify: | , Puerto Rican, atc.) | Ble | CE — American Indian, ack, White, atc. achy: White | | |
| 215 aften se as | COMPLETED | 15. DECEDENT'S E (Specify only highest gri | | 16a. DECEDENT'S | | | 16b. KIND OF BU | ISINESS/INDUSTRY | 111111111111111111111111111111111111111 | | |
| 21 tal or for u | 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | work done during se retired.) GO | v't. | | | | | |
| N N N N N N N N N N N N N N N N N N N | M M | 12 | | Supervi | sor, Pr | inting Off | | al Gover | nment | | |
| IS 2 2 | | 17. FATNER'S NAME (First, Middle, Last) | | | | | IE (First, Middle, Maiden | Sumame) | | | |
| | BE | Carl Stoker 194. INFORMANT'S NAME (Type/Print) | | 405 444 11 11 | 100000000000 | | Roberts | | | | |
| | 5 | Margie Ann Stok | or | l l | | et and Number or Rural Ro | | | 1m 00005 | | |
| SE, ay be page | | 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE | | rove Place | | Spring, | | | |
| SOR ector, p | | 1 Surial 2 Cremetion 3 Re 4 Donation 5 Other (Specify) | | cemetery, crematory or o | ther place) | | 1 | | | | |
| | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| ALTIN death. Pag s funeral dir | | Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, M | | | | | | | | | |
| 2 4 E | | 23. PART I. Enter the diseases, o | or complications that cau | ised the death. Do i | 1 TTOU | O New Hamp | snire Ave | story arrest. | Spring, MD. | | |
| | | shock for haert fellur IMMEDIATE CAUSE (Finel | e. List only one cause o | n each line. | | | | and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th | Interval Batwee Onset and Deat | | |
| tthi. 24 letely fill emation. | | disease or condition | | | | | | | | | |
| 3760 completely rial, crematific | | resulting in death) | DUE AND TON | AS A CONSEQUENCE O | F): | 12000 | | | Lyis | | |
| G8760 executed with and complet o burial, crer matte event | Z | Sequentially list anaditions | Cardio | myopa | lpy | | | | 2 yes | | |
| N4 6 0 E | CERTIFICATION | Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A ODESEQUENCE OF): | | | | | | | | | |
| BOX ficate be physician ne prior t | 일 | CAUSE (Disease or injury | Myse | seal | my | arceco | t | | Lyse | | |
| DS, P.O. B(the death certificate the attending physi i Mental Hygiene pri | Ē | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST Laterians large Heart Disease 1449 | | | | | | | | | |
| death atten | S | | - a union | - second | | | | | 149 | | |
| Q 4 4 5 6 | | PART II. Other significant conditi | ons contributing to deet | h but not reaulting | In the underly | ing cause given in P | art I, 24a. WAS AN | | Ib. WERE AUTOPSY FINDING | | |
| O = 3 = 6 | | | Lenal tailure, Chronic arral Thrillation 17 yes again con | | | | | | | | |
| /\ & 5 0 m | ă | Kenal Failu | reg Chron | ne wire | il til | rillation | 1 TYES | 2 DENO | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| RECOI | MEDIC | asciler, | Honbo | cistope | I til | rellation | | 2 (3)(40 | COMPLETION OF CAUSE | | |
| REC requires been sign to of Heal shows | AN: MEDIC | Osciles ON DID TOBACCO USE CON | TRIBUTE TO CAUSE | | S NO | UNCERTAIN | | 2 (36)10 | COMPLETION OF CAUSE OF DEATH? | | |
| TAL The law the has b are Dept. | SICIAN: MEDIC | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | ES NO TN (Check only or OTHER: | UNCERTAIN | × | 2 (30/40 | COMPLETION OF CAUSE OF DEATH? | | |
| TAL The law the has b are Dept. | HYSICIAN: MEDIC | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | HOSPITAL: | 26. PLACE OF DEA | S NO IN (Check only or OTHER: 4 Nursing N | UNCERTAIN DOME 5 Residence 6 | Other (Specify) | | COMPLETION OF CAUSE OF DEATH? | | |
| OF VITAL PHYSICIAN: The law this certificate has b with the State Dept. ked, or Item 23 | PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Inpatient 2 ER/C | 26. PLACE OF DEA | ES NO TN (Check only or OTHER: 4 Nursing N E OF 28c. I | UNCERTAIN UNCERTAIN Dome 5 X Residence 6 NJURY AT WORK? | × | | COMPLETION OF CAUSE OF DEATH? | | |
| OF VITAL PHYSICIAN: The law this certificate has b with the State Dept. ked, or Item 23 | BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation | HOSPITAL: 1 Inpatient 2 ER/C 28e. DATE OF INJU (Month, Dey, Ve) 28e. PLACE OF INJI | 26. PLACE OF DEA Outpetlent 3 DOA RY 28b. TIM INJ URY — At home, farm, 1 | S NO TN (Check only or OTHER: 4 Nursing N E OF JURY M 1 | UNCERTAIN UNCERTAIN Dome 5 Residence 8 NJURY AT WORK? YES 2 NO | Other (Specify) 28d. DESCRIBE NOW (| INJURY OCCURED | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ISION OF VITAL NTENDING PHYSICIAN: The law CTOR: After this certificate has b after death with the State Dept 28 is marked, or Item 23 | ED BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Inpetient 2 ER/C 28e. DATE OF INJU (Month, Day, Ve. | 26. PLACE OF DEA Outpetlent 3 DOA RY 28b. TIM INJ URY — At home, farm, 1 | S NO TN (Check only or OTHER: 4 Nursing N E OF JURY M 1 | UNCERTAIN UNCERTAIN Dome 5 Residence 8 NJURY AT WORK? YES 2 NO | Other (Specify) | INJURY OCCURED | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ISION OF VITAL NTENDING PHYSICIAN: The law CTOR: After this certificate has b after death with the State Dept 28 is marked, or Item 23 | ED BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined | HOSPITAL: 1 Inpetient 2 ER/U 28e. DATE OF INJU (Month, Dey, Ve.) 28e. PLACE OF INJ building, etc. (3 | 28. PLACE OF DEA Dutpetient 3 DOA RY 28b. TIM INJ URY — At home, farm, s Specify) | ES NO IN (Check only or OTHER: 4 Nursing N E OF URY M 1 street, factory, of | UNCERTAIN DOME 5 Residence 6 NJURY AT HOORK? YES 2 NO | Other (Specify) 28d. DESCRIBE NOW is City or Town, State) | INJURY OCCURED and Number or Rural | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| DIVISION OF VITAL TAL DR ATTENDING PHYSICIAN: The law UAL DIRECTOR: After this certificate has be. To hours after death with the Stare bept. If item 28 is marked, or item 23 | ED BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 ER/C 28e. DATE OF INJU (Month, Dey, Ver 28e. PLACE OF INJ building, etc. (c) | 28. PLACE OF DEA Outpetient 3 DOA RY 28b. TIM INJ URY — At home, farm, is Specify) | ES NO IN (Check only or OTHER: 4 Nursing N E OF URY M 1 street, factory, of | UNCERTAIN DOME 5 Residence 6 NJURY AT WORK? YES 2 NO Tice | Other (Specify) 28d. DESCRIBE NOW is 28f. LOCATION (Street City or Town, State) | and Number or Rural | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| DIVISION OF VITAL TAL DR ATTENDING PHYSICIAN: The law AL DIRECTOR: After this certificate has b 72 hours after death with the State Dept 11 liem 28 is marked, or liem 23 | COMPLETED BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 2 Accident Investigation 3 Suicide S Could not & detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMI | HOSPITAL: 1 Inpatient 2 ERV 28e. DATE OF INJU (Month, Dey, Yei 28e. PLACE OF INJ building, etc. (3 YSICIAN: To the best of my ki | 28. PLACE OF DEA Outpetient 3 DOA RY 28b. TIM INJ URY — At home, farm, is Specify) | ES NO IN (Check only or OTHER: 4 Nursing N E OF URY M 1 street, factory, of | UNCERTAIN DOME 5 Residence 8 NJURY AT NORK? YES 2 NO Tice ste and piace, and due to, death occured at the ti | Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Yown, State) of the cause(a) and man me, data and place, an | and Number or Rural | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Provide Number, (e) and manner as stated. | | |
| DIVISION OF VITAL TAL OR ATTENDING PHYSICIAN: The law TAL DIRECTOR: After this certificate has b 72 hours after death with the State Dept II frem 28 is marked, or liem 23 | ED BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 ERV 28e. DATE OF INJU (Month, Dey, Yei 28e. PLACE OF INJ building, etc. (3 YSICIAN: To the best of my ki | 28. PLACE OF DEA Outpetient 3 DOA RY 28b. TIM IN. URY — At home, farm, is Specify) nowledge, death occurrention and/or investigation | ES NO IN (Check only or OTHER: 4 Nursing N E OF Street, factory, of | UNCERTAIN DOME 5 Residence 6 NJURY AT WORK? YES 2 NO Tice | Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Town, State) of the cause(a) and mai me, data and place, an | and Number or Rural nner as stated, and due to the cause | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| DIVISION OF VITAL THE HOSPITAL OR ATTENDING PHYSICIAN: The law THE FUNERAL DIRECTOR: After this certificate has b filed within 72 hours after death with the State Dept. PORTANT: If Item 28 is marked, or Item 23 | BE COMPLETED BY PHYSICIAN: MEI | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 000) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIF | HOSPITAL: 1 Inpetient 2 ERV 28e. DATE OF INJU (Month, Dey, Ver 28e. PLACE OF INJ building, etc. (3) YSICIAN: To the best of my ki INER: On the bests of examin. THER WHO COMPLETED CAUSE OF YARAN A 32/REGISTERS S | 28. PLACE OF DEA Outpetient 3 DOA Outpetient 3 DOA Outpetient 3 DOA IN. URY At home, ferm, Specify) DEATH (ITEM 27) (Type, ID) Outpetient 3 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outpetient 4 DOA Outp | ES NO IN (Check only or OTHER: 4 Nursing N E OF Street, factory, of | UNCERTAIN DOME 5 Residence 8 NJURY AT NORK? YES 2 NO Tice ste and piace, and due to, death occured at the ti | Other (Specify) 28d. DESCRIBE NOW I 28f. LOCATION (Street City or Town, State) of the cause(a) and mai me, data and place, an | and Number or Rural | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO I Route Number, | | |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

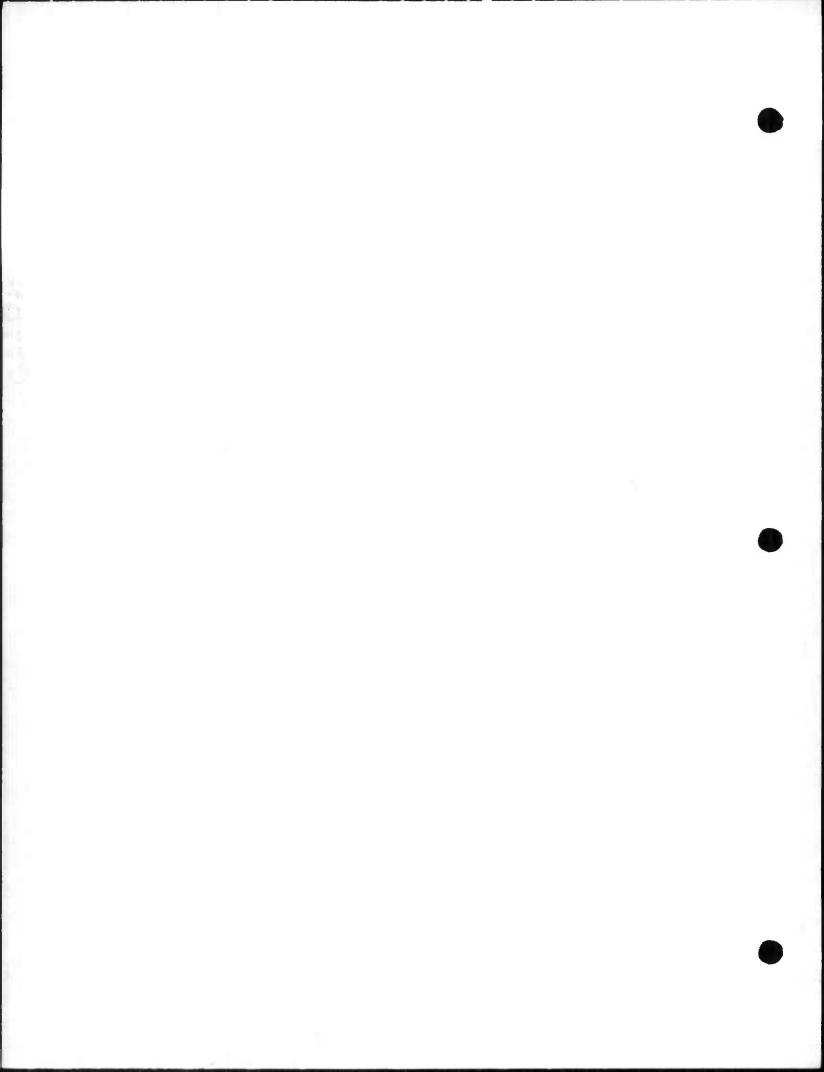
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First | DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH 3. TIME OF DEATH | | | | |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------|-------------------------------|-------------------------------------|--------------------------------------------------------------------------|---------------|------------------|-----------------------------------|--------------------------------------|----------------------------------------|---------------|-------------|-------------------------------------------|
| | Edith Ray Saul | | | | | | | | August 17, 1995 5:05 | | | | 5:05 P M | |
| | 4. SOCIAL SECURITY NUME | SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. le | ast birthday) | | | IF UNDER 24 HRS. | | 7. DATE OF | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHI | PLACE (State or Foreign |
| | 579-58-5260 1□M2⊠F 90 | | | | | MONTHS | DAYS | HOURS | MIN. | Feb. | | 1905 | New | York |
| | 9a. FACILITY NAME (If not in | stitution, give at | treet and number) | | | 9b. CITY, | TOWN (| OR LOCATI | ON OF D | | | _ | NTY OF DE | |
| DIRECTOR | Circle Manor Nursing Home | | | | | | Kens | singt | ton | | | M | lontg | omery |
| Ĕ I | 10a. STATE | 10b. COUNTY | | | 10c. CITY | , TOWN O | R LOCAT | ION | | | | | | 10d. INSIDE CITY |
| | Maryland | Mon | Kensington | | | | | | | | LIMITS? | | | |
| ¥ | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | | | | 10g. CIT | ZEN OF W | HAT COUNTRY? |
| FUNERAL | 10310 Fawc | ett St | reet | | | 20895 | | | | | | Uni | ted | States |
| | 11. MARITAL STATUS | S. ARMED 13. WAS DECENDENT OF HISPAN | | | IIC ORIGIN? (Specify Yes or No. 14. | | | | - American Indian, White, etc. | | | | | |
| B | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: Specify: | | | | | | | | | | y: | | | |
| | | | | | | | | | | White | | | | |
| COMPLETED | (Specify only Elementary/Secondary (0 | highest grade | College (1-4 or 5 | | Give kind of w | Give kind of work done during most of working a. Do NOT use retired.) | | | District of Co | | | | umbia | |
| 릴 | , | , | 5+ | | ibrar | ian | | | | Government | | | | |
| Š | 17. FATHER'S NAME (First, M | liddle, Last) | | - | | | | | HER'S NA | IAME (First, Middle, Maiden Surname) | | | | |
| BE | William L | awley | Sau1 | | | | | E1 | lma I | Ray | | | | |
| | 19a. INFORMANT'S NAME (7 | ype/Print) | | 19 | 96. MAILING | ADDRESS | (Street a | nd Number | r or Rural i | Route Number, | City or Tow | n, State, Zip | Code) | |
| Elizabeth Ray Hays Tolbert 18120 Barnesvi | | | | | | | | ille | Rd. | , Bar | nesvi | 111e, | MD | 20838 |
| | 20a. METHOD OF DISPOSITE | n 3 🗆 Remo | oval from State | cemetery, cr | AND DATE O | her place! | AIIO | net | 21. | 1985E | 20c, LO | CATION - | City or Tow | rn, State |
| | 4 □ Donation 5 □ Other 21. SIGNATURE OF UNERA | | | Rock | Creek | Cen | ne ce | Ly | | 1 | Was | hing | ton, | DC |
| | 21. SIGNATURE CONTRACT | C SERVICE LIC | ENSEE | | | Ro | bert | ADDRE | Pump | hrey | Fune | al H | ome/ | 14 |
| | Dels | -X 5 | lete- | | 0202 | Av | enue | Be | thes | sda, M | aryla | and 2 | 0814 | Wisconsin -3501 |
| i | 23. PART I. Enter the di ahock, or he | ise åse d, or c eart failure. I | omplications the | t caused the duse on each lin | eath. Do n | ot enter | the mo | de of dy | ing, auc | h aa cardlad | or reapl | ratory an | reat, | Approximate interval Batween |
| | IMMEDIATE CAUSE (Fin | | 0.00.000 | | - | | | | | | | | | Onset and Death |
| - 1 | disease or condition | → , | | bral Th | | | | | | | | | | 2 Weeks |
| _ | | | DUE 10 | (OR AS A CONSE | OUENCE OF |): | | | | | | | | |
| CERTIFICATION | Sequentially list conditi | | DUE TO | (OR AS A CONSE | OUENCE OF | 1: | | | | | | | | |
| ¥ | if any, leading to immediate. Enter UNDERLY | NG | | | | | | | | | | | | |
| | CAUSE (Disease or Inju that initiated events | | OUE TO | (OR AS A CONSE | OUENCE OF |): | | | | | | | | |
| | resulting in death) LAS | T C | l | | | | | | | | | | | |
| - 11 | PART II. Other algnifica | nt condition | s contributing to | death but not | regulting in | the un | derivino | ceuse o | given in | Part I 24 | a. WAS AN | ALITOPSV | 24h | WERE AUTOPSY FINDINGS |
| 5 | | | | | | | | | | PERFORME | | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | | | | | | | | | | - 1 | 1 D YES 2 X NO | | | OF DEATH? |
| - 16 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN | | | | | | | | | | 1 WES 2 NO | | | |
| <u> </u> | 25. WAS CASE REFERRED TO | | 10072 | | CE OF DEATH | | | 0140 | LKIAII | 101 | | - | | |
| | EXAMINER? | | HOSPITAL: | ER/Outpatient | 3 DOA | OTHER AX Num | l: ina Hom | a 5 □ Re | aldence | 6 Other /S | neolfu) | | | |
| Ĕ | 27. MANNER OF OEATH | | 28a. DATE OF (Month, D | INJURY | 28h TIME OF 28c IN HIPV AT | | | | | 26d. DESCRIBE HOW INJURY OCCURED | | | | |
| BY PHYSICIAN: | | Pending Investigation | (Month, D | ey, reary | INJU | M | | ES 2 | NO | | | | | |
| - 18 | 200 DI ACE OF IN HIRV. As home from the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of | | | | | | | | | oute Number, | | | | |
| COMPLEIED | | | | | | | | | | | | | | |
| 로 | | | CIAN: To the best of | | | | | | | | | | | |
| <u> </u> | one) 2 MEDI | CAL EXAMINER | R: On the basis of a | xamination and/or | Investigation | , In my of | olnion, d | eath occur | red at the | time, data and | d placa, and | d due to th | a cause(a) | end manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | Month, Day, Year) | | | | | |
| W 11 | 296. SIGNATURE AND TITLE | OF CENTIFIER | 1 | | | | | | | | August 18, 1995 | | | |
| | Rin | -cml (| 18 of | | _ ^ | W | | D | 0957 | 7 | | ► A | ugust | |
| | 30. NAME AND ADDRESS OF | PERSON WHO | | , | | , | | | | | | | | |
| 10 BE | 30. NAME AND ADDRESS OF Richard H. 1 | Person who | . M.D. | 10400 C | onnect | , | t Av | | | | ton, | | | |
| | 30. NAME AND ADDRESS OF | Person who | . M.D. | , | onnect | , | t Av | | | | ton, | | | 18, 1995 |



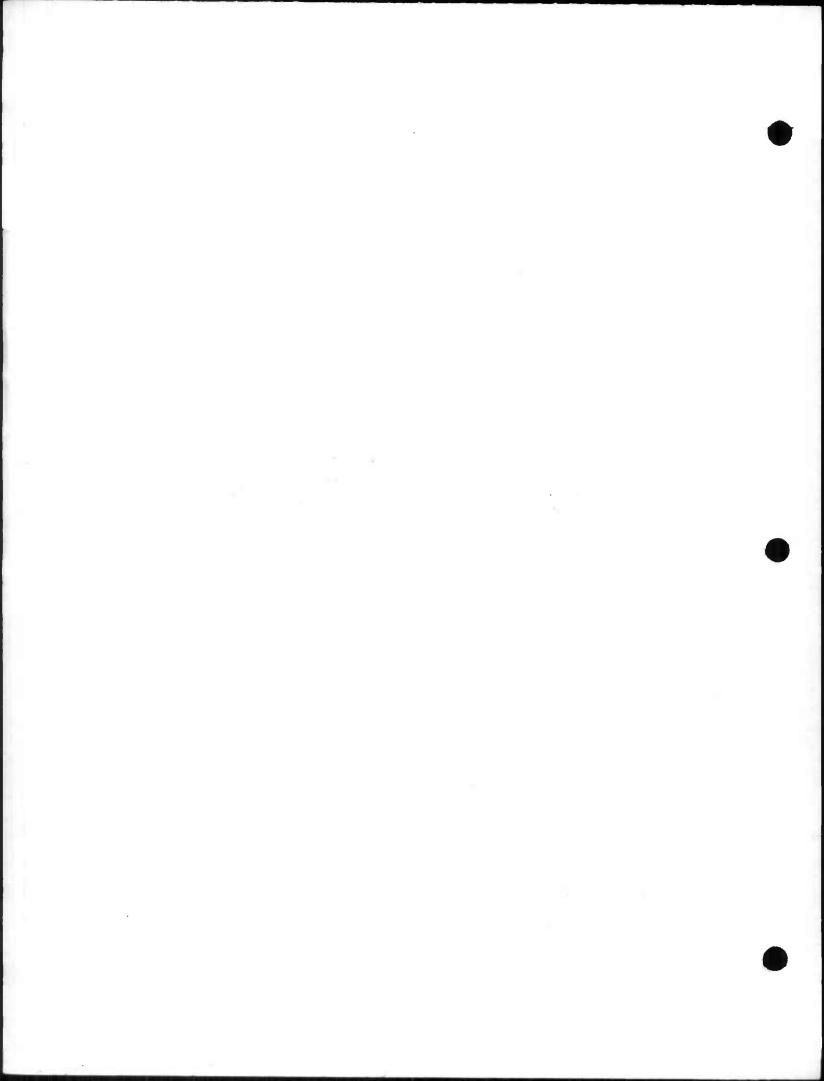


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I. 27.28a-f. PER MEO FILM G-727 9/22/95 t.t

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF I | IEALTH AND I | | GIENE a. NO. | | |
|---------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|------------------------------|---------------------------------------|-----------------------------------|------------------------------|--------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEA | | 3. TIME OF DEATH | |
| | VIRGINIA MA | RION | SPL | ETTSTC | ESZER | AUGUST | | 95 3:00 P. | |
| | 4. SOCIAL SECURITY NUMBER | | | ONTHE DAYS | IF UNDER 24 HRS. | 7. DATE OF BIR' (Month, Day,) | bar) | BIRTNPLACE (State or Foreign Country) | |
| 1 | 048-16-7083 | | 31 YRS. | | | March 3 | | Massachusetts | |
| or I | 90. FACILITY NAME (If not institution, give st 14132 WHISPERIN | | | | SPRING | | | NTGOMERY | |
| <u>ē</u> | RESIDENCE OF DECEDENT | O TINED CC | OKI | OTH VEI | DINING | | | 110//12112 | |
| DIRECTOR | 10s, STATE 10b. COUNTY | 4 | 10c. CITY, | TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? | |
| | - | gomery | Sil | ver Sp | | | | 1 TYES 2 NO | |
| FUNERAL | 104. STREET AND NUMBER | D' 0 | . #01 | 10 | I. ZIP CODE | | | IZEN OF WHAT COUNTRY? | |
| NE | 14132 Whisperin | g Pines Cour | | 12 WBS DE | 20906 ENDENT OF NISPAN | UIC OBIGIN2 (See | | ted States 14. RACE — American Indian, | |
| - 11 | 1 Never Married 2 Married | FORCES? 1 YES | 2 X NO | If yes, sp | ecity Cuban, Mexica 2 X NO Specify | n, Puerto Ricen, e | | Bleck, White, etc. | |
| ВУ | 3 🔀 Wildowed 4 🗌 Divorced | | | | Z No open, | 1, 0 | White | | |
| 日 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL O (Give kind of work done | | | | ne during most of working | | | | |
| LE I | Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Executiv | | | | atary | Amer | American Red Cross | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | DAECUCIV | e peci | | ME (First, Middle, I | | 01000 | |
| | Robert H. McVeig | jh | | | Sarah | L. Faro | uhar | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | | | and Number or Rural | | | 20000 | |
| F | Elizabeth McVeigh | | | | | | | lver Spring, MD | |
| | 20a. METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State ਟਰ | b. PLACE AND DATE OF metery, crematory or oth airview Co | DISPOSITION (No project) Aug | ust 25, | 1995™ | | City or Town, State | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | 0 M00831 | | | | | ain, Connecticut | |
| | * Barbara Gon | 10 mullen of | rulien ce | Rocky | ND ADDRESS OF FA | onrey Fu | neral R | iome/ itgomery 20850-2805 | |
| | 23. PART I. Enter the diseases, or | | | | | | | | |
| | ahock, or heart fellure. IMMEDIATE CAUSE (Final | List only one ceuse on e | eech line. | | | | | Onest and Death | |
| | disease or condition resulting in death) | SEPSIS SE | CONDARY TO | NEGLECT | | | | | |
| | , | DUE TO (OR AS | A CONSEQUENCE OF) | | | | | | |
| NO | Sequentially list conditions, | b. DUE TO (OR AS | A CONSEQUENCE OF | | = | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| IFIC | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF) | | | | | | |
| ERI | reaulting in death) LAST | d | | | | | | | |
| - 11 | PART II. Other aignificent condition | na contributing to death | but not resulting in | the underlying | g cause given in | | WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| MEDICAL | | | | | | | YES 2 NO | COMPLETION OF CAUSE OF DEATH? | |
| MEC | | | | | | _ ' | | 1 X YES 2 NO | |
| | DID TOBACCO USE CONT | RIBUTE TO CAUSE (| | | | N [8] | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH | OTHER: | | | | | |
| IYS | TX XYES 2 □ NO 27. MANNER OF DEATN | 1 Inpatient 2 ER/Out | | | ne 5 Alesidence | | NOW INJURY OF | CURED | |
| | 1 Natural 5 Pending | (Month, Day, Year) FOUND: 8-19 | FOUND | | ORK? YES 2(X) NO | | | M OF NEGLECT | |
|) BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28s. PLACE OF INJUR building, etc. (Spi | IY — At home, ferm, at | | | 281. LOCATION | (Street and Number | er or Rural Route Number, | |
| COMPLETED | 4) Nomicide determined | building, etc. (Spi | FOUND: | HOME | | COURT, # | | WHISPERING PINES LVER SPRING, MD. | |
| PLE | Check brilly | ICIAN: To the best of my know | wiedge, death occurred | I at the time, dat | e and place, and due | e to the cause(s) | ind menner as st | sted. | |
| Ö | one) 2 MEDICAL EXAMINI | ER: On the besis of examinati | on and/or investigation | , in my opinion, | death occured at the | time, date and p | lece, end due to 1 | the cause(s) and manner as steted. | |
| BE (| 296. SIGNATURE AND TITLE DE CERTIFIE | R | | | 29c. LICENSE NU | | | TE SIGNED (Month, Day, Year) | |
| TO E | 30, NAME AND CODRESS OF PERSON WIT | HO COMPLETED CAUSE OF D | SEATM //TEM 27 /3- | Onine) | 0.C.1 | M.E. | A | UGUST 20,1995 | |
| | AMOIXA | OMPLETED GAUSE OF D | | , | reet. R | altimo | re. Ma | ryland 21201 | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIG | NATURE | 50 | . J J C , D | LA CAMO. | -0, 110 | | |
| | AUG 21 1995 | Julia Davides | or Randall | | | | | | |
| | | U | | | | | | DHMH-16 Rev 1/89 | |

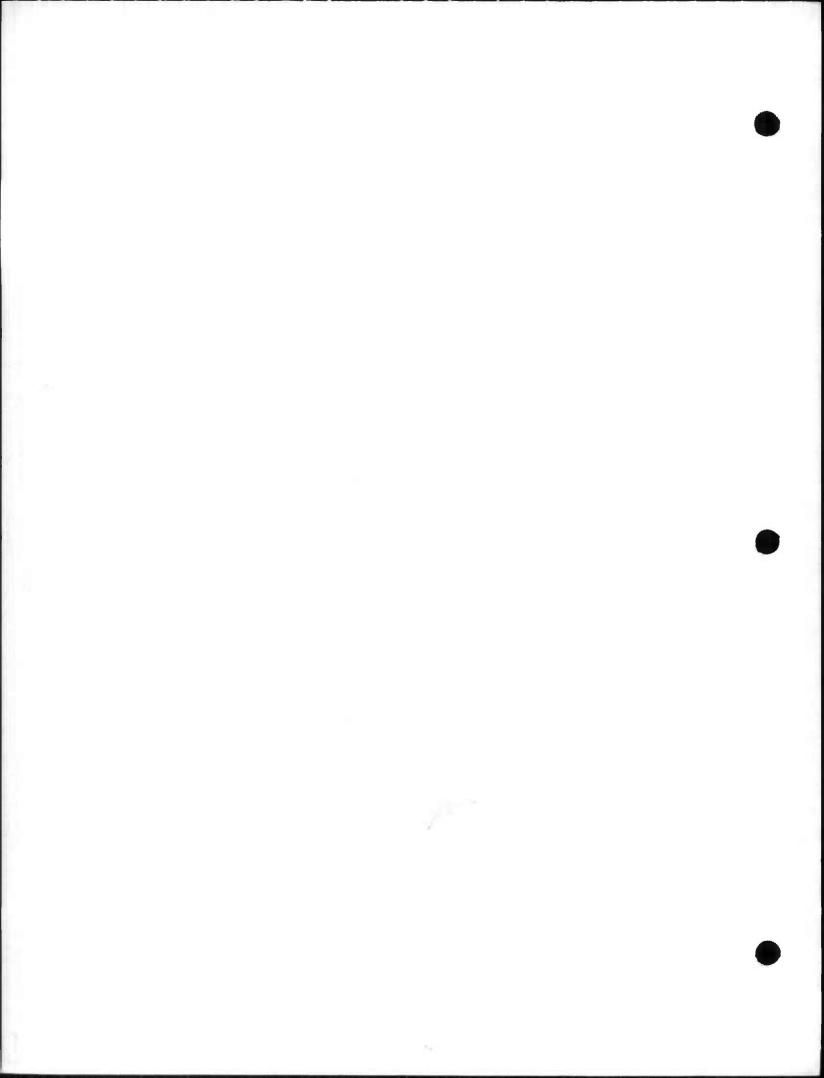


ling physician. the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Deat, of Health and Memai Hydiene prior to burial, cremation, or removal. | st once. | |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| - | y be retained to | page 5 should | be notified | |
| | ath. Page 6 ma | meral director, p | aminer must | |
| | nours after de | illed in by the fu | e medical ex | |
| | ecuted with. | nd completely fi burial, cremation | rtic event, th | |
| | ertificate be exe | Ing physician ar | other trauma | |
| | hat the death c | d by the attend | ny injury, or | |
| | e law requires t | has been signe Dept. of Health | 23 shows a | |
| | PHYSICIAN: Th | this certificate with the State | rked, or item | |
| | R ATTENDING ! | RECTOR: After urs after death | em 28 is mai | |
| | TO THE HOSPITAL O | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - STATE OF MARYL | | ENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | |
|------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------|-----------------------------|--------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | TE OF BEATTI | 2. DATE OF DEATN | | 3. TIME OF DEATN |
| | Alexander C. Smoling | | | August 17, | 1 Q Q S | 8:57 P M |
| | | (In yrs. lest birthday) IF L | NDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTN | PLACE (State or Foreign |
| | 082-05-8667 ¹¼™²□F 84 | YRS. MON | HS DAYS HOURS MIN. | (Month, Day, Year) Jan. 12, 19 | Country | 0 |
| _ | 9a. FACILITY NAME (If not institution, give street and number) | CITY, TOWN OR LOCATION OF DE | ATN | 9c. COUNTY OF DI | EATN | |
| DIRECTOR | 1926 Merrifields Drive | Silver Spring | 3 | Montgo | mery | |
| Ĭ, | 10e. STATE 10b. COUNTY | t0c. CITY, TO | WN OR LOCATION | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Montgomery | Si1 | ver Spring | | | t TYES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | 101. ZIP CODE | | 10g. CITIZEN OF W | HAT COUNTRY? |
| Ü | 1926 Merrifields Drive | | 20906 | | United | States |
| F | 11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES | 2 X NO | 13. WAS DECENDENT OF NISPAN If yes, specify Cuban, Mexica | n, Puerto Rican, etc.) | No- 14. RACE Black | — American Indian, , White, atc. |
| B | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR D. | ATES | 1 YES 2 X NO Specify | <i>f</i> : | Specify: White | |
| | 15. DECEDENT'S EDUCATION | 16a. DECEDENT'S USUA | L OCCUPATION | IESS/INDUSTRY | WILLE | |
| E. | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | (Give kind of work of life. Do NOT use reti | one during most of working ed.) | New York | c City | 100 |
| MPL | 10 | Firem | an | Fire Dep | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | 18. MOTHER'S NA | ME (First, Middle, Maiden Su | mame) | | |
| BE | Kalman Smoling | Elizat | eth Sinsky | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | RESS (Street and Number or Rural I | | | | |
| | Linda Smoling Moore | 1926 Me | rrifields Driv | e, Silver S | | |
| | 20b 1 □ Burial 2 № Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | netery, crematory or other p | POSITION (Name of ace) August 18, 1 | 1995 20c. LOCA | TION — City or To | |
| | V Domation 3 Cl Other (Specify) | ionigomerv | Gremarorium. I | nc lberne | esda, Ma | ryland |
| | 76 1 (1700 700 1/1 2) | whence | A NAME AND ADDRESS OF FA ROBert A. Pump Rockville, Inc Avenue, Rockvi | hrey Funera | 1 Home/ | merv |
| <u> </u> | 22 BART I Sater the disease or completely the same | 1 1 1 1 5 | Avenue, Róckvi | lle, Maryla | and 2085 | |
| | 23. PART I. Enter the diseases, or complications that cause abock, or heart fallure. List only one cause on e | ech line. | nter the mode of dying, suc | h as cardiac or respirat | tory arrest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | Onset and Death | | | |
| | resulting in death) a. Myocardial | . Intarctio | n-Acute | | | l hour |
| _ | | | | | | j |
| ō | Sequentially list conditions, If any, leading to immediate | A CONSEQUENCE OF): | | | | |
| 2 | CAUSE. Enter UNDERLYING CAUSE (Disease or Injury | | | | | |
| TIF | that initiated events DUE TO (OR AS A reaulting in death) LAST | A CONSEQUENCE OF): | | | | |
| CERTIFICATION | d. | | | | | |
| AL C | PART II. Other significant conditions contributing to deeth b | out not resulting in th | underlying ceuee given in | Part I. 24s. WAS AN AU | | WERE AUTOPSY FINDINGS |
| | Chronic Neurogenic Swallowi | ng Disorde | r, Atrial | PERFORMI | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | Fibrillation, Chronic Conju | nctivitis, | Pancytopenia | | | t TYES 2 X NO |
| ä | DID TOBACCO USE CONTRIBUTE TO | CAUSE OF DE | ATH YES NO | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | OT | 26. PLACE OF DEATH (Chi | eck only one) | | |
| YSI | 1 ☐ YES 2 NO 1 ☐ InpetIent 2 ☐ ER/Outs | petient 3 DOA 4 D | Nursing Nome 5 X Residence | | | |
| F | 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. OEŞCRIBE HOW INJI | URY OCCUREO | |
| ВУ | 2 Accident Investigation | / — At home, farm, street | 1 YES 2 NO | 28f. LOCATION (Street and | Alumbaa sa Busal B | |
| COMPLETED | 3 Suicide 8 Could not be 4 Nomicide 8 Could not be detarmined 28a. PLACE OF INJURY building, etc. (Spec | cify) | ractory, ornea | City or Town, State) | Number of Nurei N | oute Number, |
| | 29a. CERTIFIER (Check only) 1 X CERTIFYING PHYSICIAN: To the best of my know | dadas daeth sammed at | | | ova-iu | |
| MP | (Check only one) 2 MEDICAL EXAMINER: On the best of examination | | | | | and menner as atated. |
| | 215 SIGNATURE AND TITLE OF CERTIFIER | W 100 4000 | 29c, LICENSE NUM | | 19d. DATE SIGNED | |
| BE | D. Harrin W AH | Endin Phy | S . D350 | | | 17, 1995 |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE | ATN (ITEM 27) (Type, Press | 1 0000 | T-2 | August | 17, 1773 |
| | Philip Henjum, M.D. 3416 01 | andwood Cou | rt, #200, 01n | ey, Marvlan | d 20832 | 2 |
| . 1 | 24 DATE FILED (March One Ward | IATUDE | | , | | |
| | 31. DATE FILED (MONTH, Doy, Mar) AUG 21 1995 Julia Davidson | Pila | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

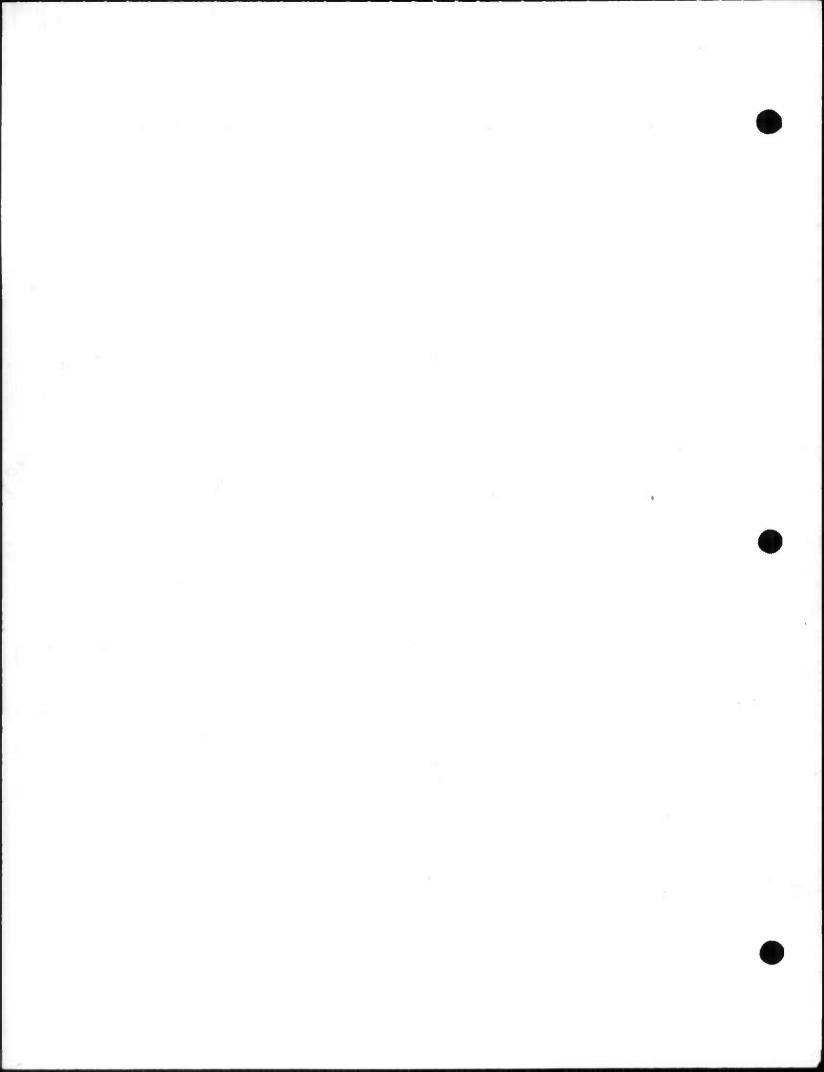
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR

| | HEOISTHAN | | | ENTIF | CALE | UF | DEA | П | P | REG. NO. | | | |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------|----------------------|------------|----------------|------------------------------|-------------|-------------|-----------------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATN |
| 1 | | Gnesina D |). Santi | ni | | | | | Augus | | | YEAR | 7:45 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la | st birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7 DATE OF I | BIETH | 1200 | | IPLACE (State or Foreign |
| | 213-42-8682 | 1 🗆 M 2 🕃 F | 88 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, De | y, Ybar) | | Countr | (Y) |
| | 9a. FACILITY NAME (If not institution, give a | trant and number | 00 | | * OF THE | - | | | May 1 | 4,19 | | | hington, DC |
| œ | | | | | | | | 9c. COU | INTY OF D | EATH | | | |
| 2 | Grosvenor Health | Care Cer | iter | | | В | ethe | sda | | | Mo | ntgoi | mery |
| DIRECTOR | 10a. STATE 10b. COUNTY | 1 | | Tage CITY | Y, TOWN O | OR LOCAT | TION | | | | | | |
| E | Maryland Mo | n+~~~~ | _ | 100.00 | D-+h3- | | | | | | | 10d, INSIDE CITY LIMITS? | |
| | 10e. STREET AND NUMBER | ontgomery | | 1 | Bethesda | | | | | 1 YES 2 XNO | | | |
| Z | 1100-90-330-1 180- | | | | | 101 | ZIP CODE | E | | | 10g. CIT | IZEN OF V | VHAT COUNTRY? |
| ÿ | 5721 Grosvenor La | ane | | | 20814 U | | | Uni | ted S | States | | | |
| FUNERAL | 1t. MARITAL STATUS | 12. WAS DECEDEN | | | | | | t4. RACE | - American Indian, | | | | |
| ВУ | 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced FORCES? 1 ☐ YES 2 ☑ IF YES, GIVE WAR OR DATES | | | | If yes, specify Cuban, Maxican, Puarto Rican, etc.) t ☐ YES 27☐NO Specify: Specify: | | | k, White, etc. | | | | | |
| | SK WOMES 4 DIVOICES | | | | | | 2121 | | | | | | White |
| | 15. DECEDENT'S EDUC (Specify only highest grade | | | | DENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INI kind of work done during most of working | | | | | DUSTRY | | | |
| 9 | Elementary/Secondary (0-12) | | | | | Do NOT use retired.) | | | | | | | |
| P P | 12 Se | | | creta | retary | | | | At | torn | ey | | |
| COMPLETED | t7. FATHER'S NAME (First, Middle, Last) | t7. FATHER'S NAME (First, Middle, Last) | | | | | ts. MOTH | NER'S NAM | IE (First, Middl | e, Meiden | Surname) | | |
| | Vincent DeNu | ınzio | | | | | 1 | Emeli | ia Lup | 0 | | | Aug T |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS | (Street a | | | oute Number, C | | State 7ir | n Code) | |
| 2 | Frank Vincent Sar | ntini | | | | | | | k, Ma | | | 21705 | |
| | 20a. METHOD OF DISPOSITION | | | | | | | | | | - | | |
| | t Burial 2 CCremation 3 Remo | oval from State | cemetery, cre | and date of metory or of | F DISPOSI her place) | Aug | ust : | 21, 1 | 1995 | | | City or To | |
| | 20b. PLACE AND DATE OF DISPOSITION 2 December 2 Decem | | | | | | | aryland | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. P | NAME AN | O ADDRES | SS OF FACE | Rol | bert | A. 1 | Pumph | rey Funeral |
| - | ►// 4 . A . s . (5 | 1 X | To | 00040 | Ho | me/l | Rocki | ille | , Inc | ., 30 | 00 W. | . Mor | ntgomery Ave |
| | 23. PART I. Enter the diseases, or c | complications that | caused the de | 00348 | I Ro | ckv: | ille. | Mar | vland | 208 | 350-2 | 2805 | |
| - 1 | shock, or heart failure. I | List only one cau | se on each line |), | or sinter | the mo | de or dyr | ng, such | aa cardiac | or respi | ratory an | reat, | Approximate interval Between |
| - 1 | IMMEDIATE CAUSE (Final | | | | | | | | Onset and Death | | | | |
| ļ | reaulting in death) | | osclero | | | | | | | | | | Years |
| - 1 | | DUE TO | (OR AS A CONSE | DUENCE OF |): | | | | | | | | |
| Z | Sequentially list conditions, | b | | | | | | | | | | | |
| EDICAL CERTIFICATION | if any, leading to immediate | DUE TO | OR AS A CONSE | QUENCE OF |): | | | | | | | | |
| 2 | CAUSE, Enter UNDERLYING CAUSE (Disease or injury | L | | | | | | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO | (OR AS A CONSE | DUENCE OF |): | | | | | | | | |
| H | resulting in death) LAST | i | | | | | | | | | | | |
| 0 | PART II. Other aignificant conditions | e contributing to | double but not a | saulilaa l | - Alva | 4 -1 1- | | | | | | | |
| X I | Dementia | e contributing to | death but hot i | esuiting i | n the une | aeriying | cauae g | iven in P | art i. 24a | PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | Dementia | | | | | | | | t [| YES 2 | ONX | | COMPLETION OF CAUSE OF DEATH? |
| ME I | | | | | | | | | | | | - 1 | t TYES 2 TXNO |
| | DID TOBACCO USE CONTR | RIBUTE TO CA | USE OF DEA | TH YE | S D N | 10 X | UNC | ERTAIN | | | | | - A |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | E OF DEAT | | | | | | | | | |
| 25 | EXAMINER? t ☐ YES 2 ☐XNO | HOSPITAL: 1 Inpetient 2 | FR/Outpetlant 3 | □ noa | OTHER | l; | | | | | | | |
| Ĕ | 27. MANNER OF DEATN | 26a. DATE OF | | 26b. TIME | | 28c. INJ | | - | Other (Spi | | LINEY OO | CUREO | |
| | 1 Natural 5 Pending | (Month, De | | ILNI | | WO | RK? | | 200. DESCRIE | PE NUW IN | IJUNT OCI | COHED | |
| B⊀ | 2 Accident Investigation | 28a PLACE OF | E IN SURV. As he | - 4 | | | ES 2 | - | | | | | |
| | 3 Suicide 6 Could not be 4 Nomicide detarmined | building, | F INJURY — At ho etc. (Specify) | me, rami, s | reet, racto | эгу, опис | • | 1 | 26f. LOCATION City or Tox | | nd Number | or Rural R | oute Number, |
| Ē. | | | | | | | | | | | | | |
| 집 | (Check only 1 X CERTIFYING PHYSIC | CIAN: To the beat of | my knowledga, de | ath occurre | d at the tir | me, data | and place, | and due to | o the cause(a) | and man | ner as stat | ted. | |
| COMPLET | one) 2 MEDICAL EXAMINES | | | | | | | | | | | | and manner as stated. |
| | 29b. SIGNATURE AND FITLE OF CERTIFIER | 0 0 | | | | | | NSE NUMB | | - | | | |
| B | 4/1 | bak | IVIN | | | | | | | | | | (Month, Day, Year) |
| 2 | 30. HAM AND ADDRESS OF PERSON WHO | COMPLETE | , ,,, | | | | D | 2051 | 6 | | At | ıgust | 11, 1995 |
| | 1/ | | | | | | | | | | | | |
| | 9410 Old George | town Road | l Bethe | sda, | Mary | ylan | d 20 | 0814 | | | | | |
| | 31. DATE AUG 23 1995 | 32. REGISTRA | S SIGNATURE | 11. | | | | | | | | | |
| | 69 1999 | The wind | ישטיר יישטייטיטיטיטיי | ~V | | | | | | | | | |



YEAR

3. TIME OF DEATH

TYES 2 NO

Approximate Interval Between

Onset and Desth

Week

3 yemis

24b. WERE AUTOPSY FINDINGS

8. BIRTHPLACE (State or Foreign

New York

14. RACE — American Indian, Black, White, atc.

Specify: White

Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death.

Pages 1, 2, 3 should

permit.

use as the burial-transit

page 5 should be detached for

the funeral director,

this certificate has been signed by the attending physician and completely filled in by with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo

DIRECTOR

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CERTIFICATION

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| DIVISION OF VITAL RECORDS, P.O. BOX 6876 | 9 | S | 2 | S |
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comp | 23 | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic eve |
| | Ë | A | 17 | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Max Sachs August 1995 8. AGE (in yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) Dec 31,1914 IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 | F 577-40-6629 80 9s. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Meridan/Aspenwood Nursing Center Silver Spring Montgomery RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION MD Montgomery Silver Spring 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15300 Walbrook Ct Apt 3B 20906 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Maxican, Puerto Rican, etc.)
 \[\subseteq \text{YE} NO \quad \text{Specify:} \] FORCES? 1 YES 2 NO 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Cartographer Gov't 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Morris Aaron Sachs Sarah Shapiro 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Florence Sachs 15300 Wallbrook Ct Apt 3B Silver Spring MD 20906 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Lebanon Cemetery 8/25 Olney MD 21. SIGNATURE OF FUNERAL SE 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Directic 1091 Rockville Pike Rockville MD 20852 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fallure. List only one cause on each line. **IMMEDIATE CAUSE (Finei** disease or condition Leuk-emi A resulting in death) s. A CUTE DUE TO (OR AS A CONSEQUENCE OF): · myelo PROLIFERATIVE DISORDER Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events. resulting in desth) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY

| DID TOBACCO USE CONT | | | NO UNCERTAI | 1 YES 2 p(NO | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|-------------------------------------------------------------------|-------------------------------------------------------|-----------------------------|----------------------------------|---------------------------------------------------------------|-------------------------------------------|
| 25. WAS CASE REFERRED TO MEDICAL | 28. PLAC | CE OF DEATH (Check | conly one) | | |
| 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 | DOA 4 Nu | R: rsing Home 5 - Residence | 6 Other (Specify) | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c, INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCUR | ED |
| 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, farm, street, fac | ctory, office | 281. LOCATION (Street and Number or I City or Town, State) | Rural Route Number, |
| 290. CERTIFIER (Check only 1 CERTIFYINO PHYS | ICIAN: To the best of my knowledge, de | eath occurred at the | time, data and place, end due | to the ceuse(s) end manner ee stated. | |

2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, data end place, and due to the ceuse(e) end manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) a. Rroo Ry D 24543 8-24-95

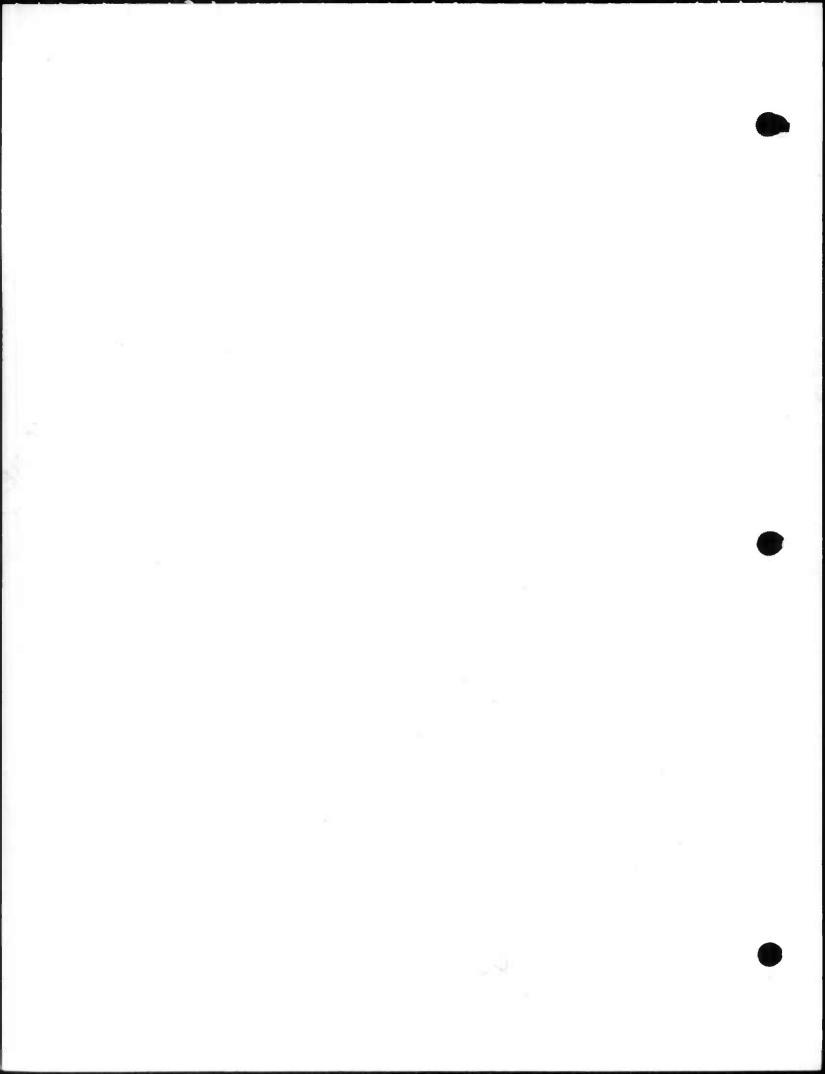
AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JAMES A. ROSSI WONT LEISURY WORLD, 33 05 , M. D.

31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE Daviles 1995

DHMH-16 Rev 1/89

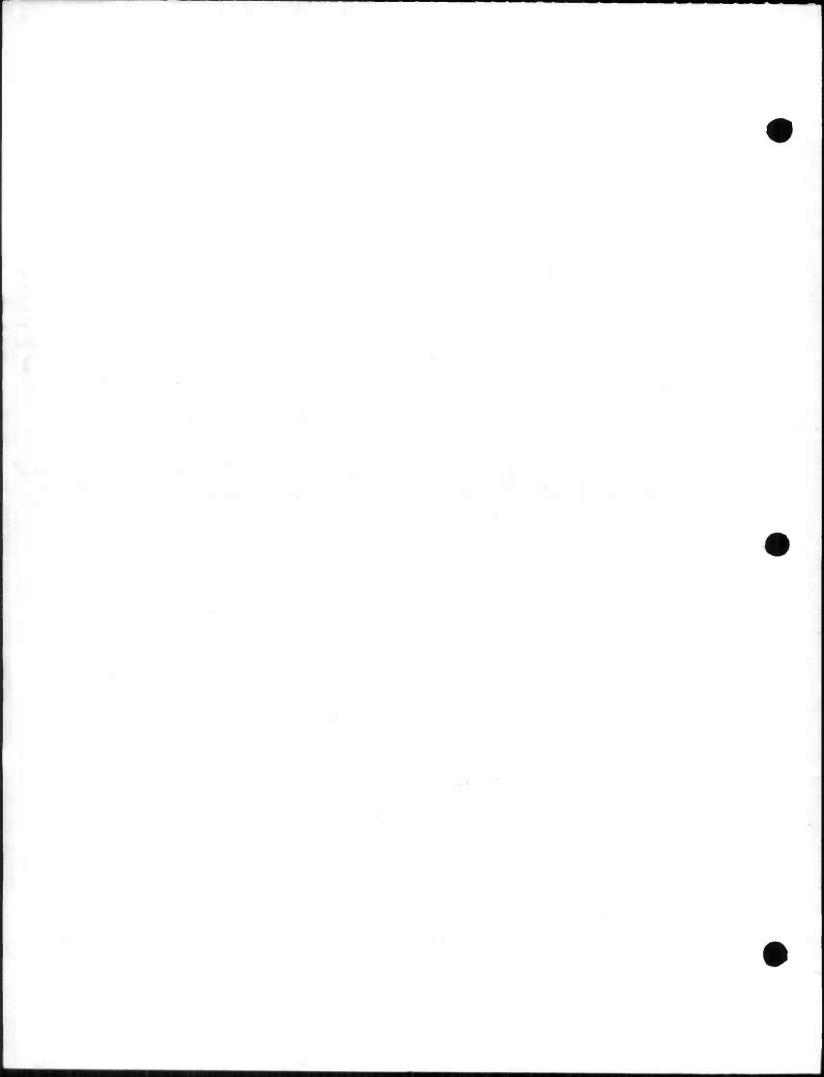
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | be filed within 72 hours after death with the State Dept. of Health and Mertal Hygiene prior to bunial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| ficate be en | physician : | ne prior to | er traum |
| death certif | aftending | ental Hygier | ry, or oth |
| es that the | and by the | afth and Me | s any Inju |
| law require | as been sig | Dept. of Hea | 23 shows |
| INCIAN: The | certificate h. | the State L | , or Item |
| DING PHYS | After this o | death with | s marked |
| OR ATTEN | DIRECTOR | hours after | Item 28 I |
| TO THE HOSPITAL | TO THE FUNERAL | be filed within 72 | IMPORTANT: If |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | | ENT OF HEALTH | | TAL HYGIENI REG. NO. | | | |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|
| | 1. DECEDENT'S HAME (First, Middle, Last) | | JEITH 10 | TIE OF DEA | | ATE OF DEATH | | 3. TIME OF DEATH | |
| | ROSEMARY | L. | S | EIM | | GUST 2 | | 01:15 A M | |
| | | S. SEX 8. AGE (In yrs. | last birthday) IF | UNDER 1 YEAR IF UNDE | R 24 HRS. 7. D/ | TE OF BIRTH | B. BIR | THPLACE (State or Foreign | |
| | 216 60 1905 | □ M 2 💢 F 4 2 | YRS. | THE DAYS HOURS | MIN. M' | March 19,1953 MARYLAND | | | |
| | 9a. FACILITY HAME (If not institution, give street | it and number) | 9b. | CITY, TOWN OR LOCAT | IOH OF DEATH | | 9c. COUHTY OF | DEATH | |
| OR | RT 2 AND RT 4 S | PLIT | | HUNTINGTO | INGTOWN CALVERT | | | | |
| DIRECTOR | 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | 10d. IHSIDE CITY | | |
| DIR | MD. MONTO | GOMERY | SII | VER SPRI | NG | | | LIMITS? | |
| | 10e. STREET AND HUMBER | | | 10f. ZIP COE | | | | WHAT COUHTRY? | |
| FUNERAL | 2208 COLSTON DR | IVE #302 | | | 20901 | | U.S | .A. | |
| 5 | | 2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 | | 13. WAS OECENOENT It yes, specify Cub | OF HISPANIC OR | IGIN? (Specify Yea | or No- 14. RA | CE — American Indian, ick, White, atc. | |
| ВУ | XX Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TYES 2 XNO | Specify: | | Sp | WHITE | |
| ED | 16. DECEDENT'S EDUCA | FIOH 16a. | DECEDENT'S USL | IAL OCCUPATION | | 16b. KIND OF BUS | INESS/INDUSTRY | | |
| ETE | (Specify only highest grade co | mpleted) College (1-4 or 5+) | (Give kind of work life. Do NOT use rea | done during most of work ired.) | ing | | | 7.0 | |
| IPL | | | CHOOL 7 | TEACHER | | PUBL] | C SCHO | OOLS | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | rst, Middle, Maiden | | | |
| BE (| IOWELL E | . SE | IM | RU | JTHE | KII | LIAN | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | ORESS (Street and Number | | | | MD. 2091 | |
| - | RUTH PENDLETON | | | | | | | | |
| | 20a. METHOD OF DISPOSITIOH 1 Burlal 2 X X remation 3 Remove | of fence Ctate | | ISPOSITION (Name of place) | 1 | | CATION — City or | ANDRIA, VA. | |
| | 4 Donation 5 Other (Specify) | | ROPULT. | | | | | | |
| | an. 100 | Q' | | TAKOMA | Fun | EFAI | TOME | 254 Carro | |
| | Mural O | som con | death Death | 5T. N. | | | _ | DC 20012 | |
| | 23. PART I. Enter the diseases, or co- ahock, or heart failure. Li | st only one cause on each | lina. | enter the mode of d | ying, auch as | cardiac or reapi | nory arrest, | Approximate Interval Between | |
| | IMMEDIATE CAUSE (Final disease or condition | M. lenl | | 7- | | | | Onset and Death | |
| | resulting in death) a. | DUE TO (OR ANA CON | SEQUENCE OF: | 102 | | | | | |
| _ | | 4 | | | | | | | |
| 0 | Sequantielly liet conditions, If any, leading to immediate | DUE TO (OR AS A CON | ISEOUENCE OF): | | | | | | |
| CA | cause, Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | |
| TIF | that initiated events resulting in death) LAST | OUE TO (OR AS A CON | SEOUENCE OF): | | | | | | |
| CERTIFICATION | d. | | | | | | | | |
| AL 0 | PART II. Other algolificent conditione | contributing to death but n | ot rasulting in t | he underlying cause | given in Part | L 24a. WAS AH PERFOR | | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| SC. | | | | | | 1 YES 2 | | COMPLETION OF CAUSE DF DEATH? | |
| MEDIC | | | | | | - | | / | |
| | | | | | | | - 11 | 1 YES 2 NO | |
| ä | DID TOBACCO USE CONTRI | | | | CERTAIN [|] | | 1 YES 2 NO | |
| CIAN: | 25. WAS CASE REFERRED TO MEDICAL | | LACE OF DEATH | | CERTAIN [| 1 | | 1 YES 2 NO | |
| YSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PHOSPITAL: 1 □ Inpatient 2 □ ER/Outpatien | t 3 DOA 4 | Check only one) THER: Hursing Home 5 1 | Rasidence 8 | Other (Specify) S | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. P | t 3 DOA 4 | Check only one) THER: Hursing Home 5 1 1 F 28c. INJURY AT WORK? | Rasidence 8x1 | Other (Specify) S | | 18 YES 2 NO | |
| ВУ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1YES 2 NO 27. MAHNER OF DEATH 1 Hatural 5 Pending Investigation | 28. PHOSPITAL: Inpatient 2 ER/Outpatien 28s. DATE OF IHJURY (Mark), Day, War) | LACE OF DEATH (1 3 DOA 4 DOA INJURY) | THER: Hursing Home 5 1 1 F 28c. INJURY AT WORK? M 1 YES 2 | Rasidence 6x 28g | Other (Specify) S OESCRIBE HOW I | BUS | R STEWK | |
| ED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1YES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending | 26. PHOSPITAL: 1 Inpatient 2 ER/Outpatient 26e. DATE OF IHJURY | t home, farm, street | THER: Hursing Home 5 1 1 F 28c. INJURY AT WORK? M 1 YES 2 | Residence 6 28d | Other (Specify) S | Bus and Number or Pur | R STERRE | |
| ETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined | 28. PLACE OF INJURY — A building, atc. (Specily) | t a DOA 4 28b. TIME 0 INJURY 1 t home, farm, stree | Check only one) THER: Hursing Home 5 1 F, 28c. INJURY AT WORK? M 1 YES 2 M, tactory, office | Rasidence & 28d | Other (Specify) S OESCRIBE HOW I SECULATION (Street City or Town, State) | BUS and Number or Pur HUNTI | R STERRE | |
| ETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER [Check unity] | 28. PHOSPITAL: 1 Inpartient 2 ER/Outpetlen 28e. DATE OF IHJURY (Mgath, Day, Wear) 28e. PLACE OF INJURY — A building, atc. (Specify) AH: To the best of my knowledge | t 3 DOA 4 28b. TIME 0 INJURY 1 t home, farm, stree | Check only one) THER: Hursing Home 5 1 F 28c. INJURY AT WORK? M 1 YES 2 It, tactory, office | Rasidence 6,5 28d 28d 28d 28d 28d 28d 28d 28d 28d 28d | Other (Specify) S OESCRIBE HOW I S LOCATION (Street City or Town, State) | BUS and Number or Rur AT HUNTII | R STEWER al Route Number, NOTOWN | |
| COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | 28. PLACE OF INJURY — A building, atc. (Specily) | t 3 DOA 4 28b. TIME 0 INJURY 1 t home, farm, stree | Check only one) THER: Hursing Home 5 1 F | Residence 647 28d NO 28f. 28f. 28f. 28f. 28f. 28f. 28f. 28f. | Other (Specify) S OESCRIBE HOW I S LOCATION (Street City or Town, State) | But and Number or Rur HUNTI/ | R STEURC If Route Number, VOTO UN e(s) and menner as stated. | |
| BE COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER [Check unity] | 28. PHOSPITAL: 1 Inpartient 2 ER/Outpetlen 28e. DATE OF IHJURY (Mgath, Day, Wear) 28e. PLACE OF INJURY — A building, atc. (Specify) AH: To the best of my knowledge | t 3 DOA 4 28b. TIME 0 INJURY 1 t home, farm, stree | Check only one) THER: Hursing Home 5 1 F | Residence 647 28d 28d 28d 28d 28d 28d 28d 28d 28d 28d | Other (Specify) S OESCRIBE HOW I S LOCATION (Street City or Town, State) Course(a) and mandeta and place, and | But and Number or Rur HUNTI/ | R STEUME If Route Number, VOTO UN e(s) and menner as stated. ED (Month, Day, Year) | |
| E COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER 1 CERTIFYING PHYSICIONS 29b. SIGNATORN AND TITLE OF CERTIFIER | 28. PHOSPITAL: 1 Inpartient 2 ER/Outpetlen 28e. DATE OF IHJURY (Mgath, Day, Wear) 28e. PLACE OF INJURY — A building, atc. (Specify) AH: To the best of my knowledge | t 3 DOA 4 ON A STATE OF DEATH (I | Check only one) THER: Hursing Home 5 1 F 28c. INJURY AT WORK? M 1 YES 2 pt, tactory, office It the time, data and piece on my opinion, deeth occ | Residence 647 28d NO 28f. 28f. 28f. 28f. 28f. 28f. 28f. 28f. | Other (Specify) S OESCRIBE HOW I S LOCATION (Street City or Town, State) Course(a) and mandeta and place, and | But and Number or Rur HUNTI/ | R STEURC If Route Number, VOTO UN e(s) and menner as stated. | |
| BE COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER 1 CERTIFYING PHYSICIONS 29b. SIGNATORN AND TITLE OF CERTIFIER | 28. PHOSPITAL: 1 Inpartient 2 ER/Outpetlen 28a. DATE OF IHJURY (Mgath, Day, War) 28a. PLACE OF INJURY — A building, atc. (Specify) AH: To the beat of my knowledge On the beata of examination and | LACE OF DEATH (I | Check only one) THER: Hursing Home 5 1 F 28c. INJURY AT WORK? M 1 YES 2 It, tectory, office It the time, data and piece In my opinion, death occ | Residence 642 25d 25d 25d 25d 25d 25d 25d 25d 25d 25 | Other (Specify) S OESCRIBE NOW I LOCATION (Sireet City or Town, State) City or Town, State) curse(a) and maidata and place, and | and Number or Rur HUNTIV There as stated. Indiduction the cause 29d. DATE SIGN AUGU | R STEUME If Route Number, VOTO UN e(s) and menner as stated. ED (Month, Day, Year) | |
| BE COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MAHNER OF DEATH 1 Hetural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER 1 CERTIFYING PHYSICIONS 29b. SIGNATORN AND TITLE OF CERTIFIER | 28. PHOSPITAL: 1 Inpartient 2 ER/Outpetlen 28a. DATE OF IHJURY (Mgath, Day, War) 28a. PLACE OF INJURY — A building, atc. (Specify) AH: To the beat of my knowledge On the beata of examination and | t a DOA 4 1 28b. TIME 0 INJURY 0 1 90 1 1 1 1 Pe | Check only one) THER: Hursing Home 5 1 F 28c. INJURY AT WORK? M 1 YES 2 It, tectory, office It the time, data and piece In my opinion, death occ | Residence 642 25d 25d 25d 25d 25d 25d 25d 25d 25d 25 | Other (Specify) S OESCRIBE NOW I LOCATION (Sireet City or Town, State) City or Town, State) curse(a) and maidata and place, and | and Number or Rur HUNTIV There as stated. Indiduction the cause 29d. DATE SIGN AUGU | el Route Number, NaTour e(s) and menner as stated. ED (Month, Day, Year) ST 20 1995 | |

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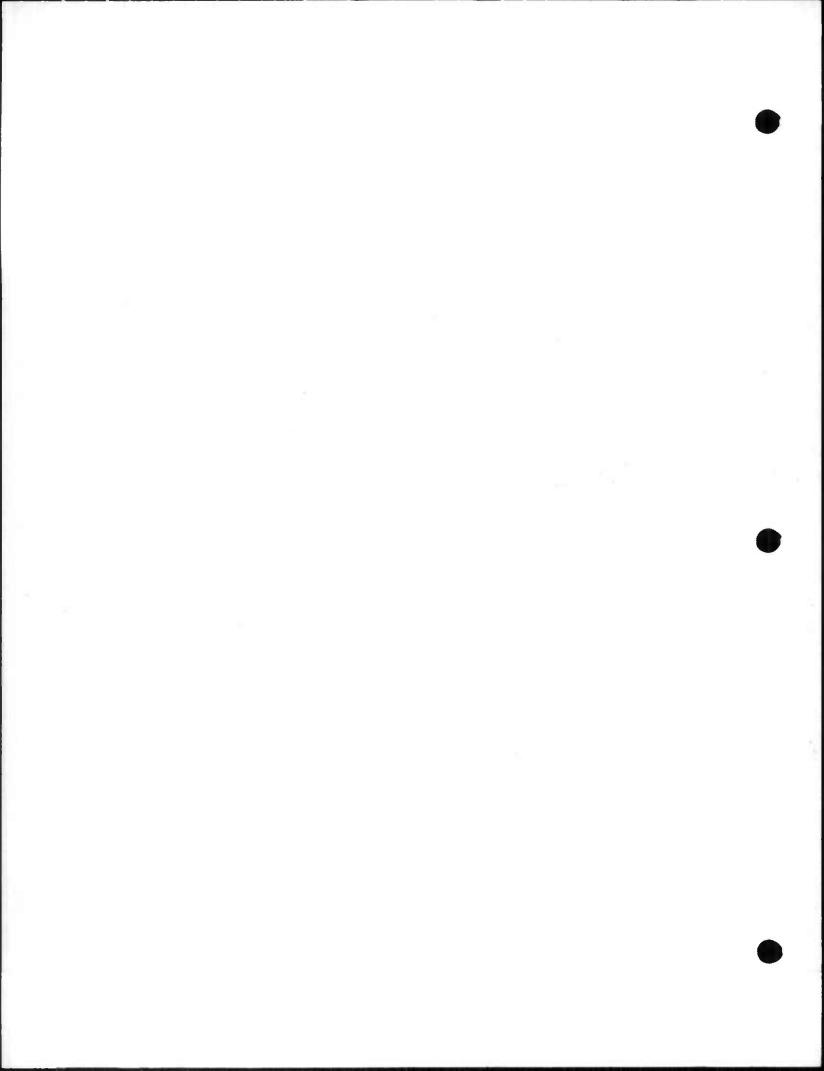
DIVISION OF VITAL RECORDS,

10

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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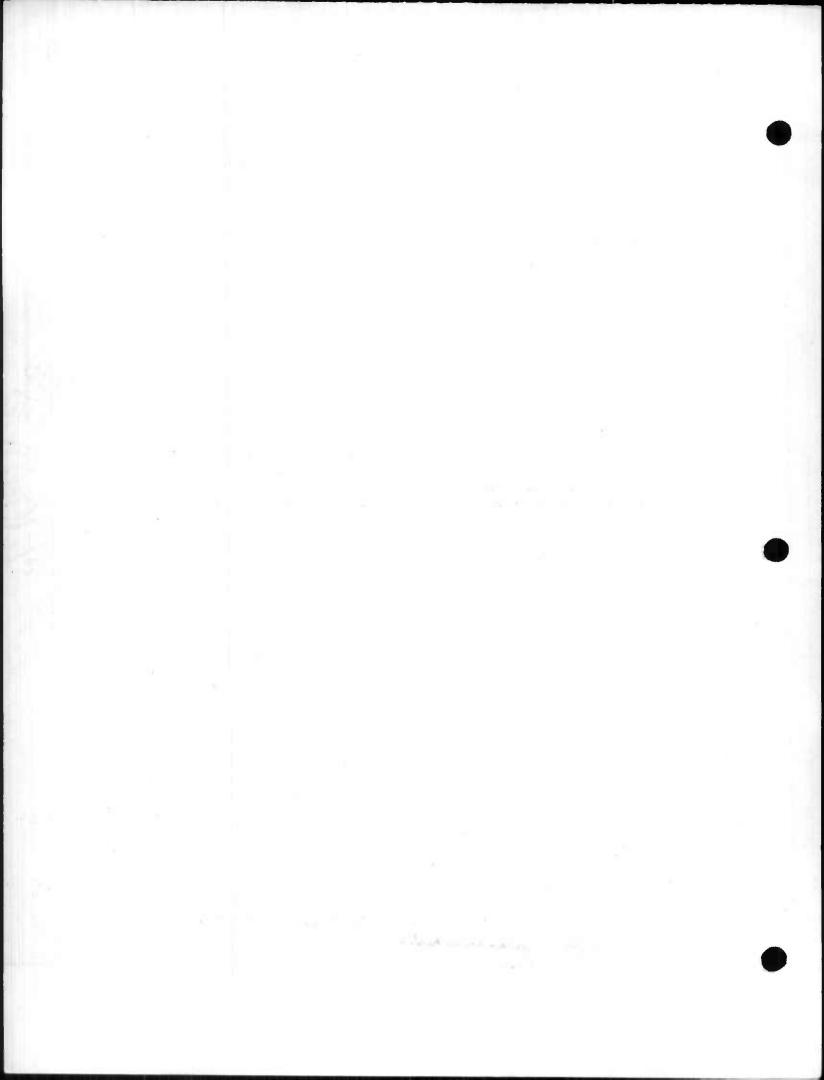
| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF HE | | MENTAL HYGIENI | E | |
|---------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------|---------------------|--------------------------------------------------|-------------------------|-----------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| 1 | | Ann Paulet | t | Stirli | ng | August 22 | | 8:00 A M |
| | 4. SOCIAL SECURITY NUMBER | | | | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT | HPLACE (State or Foreign |
| | 217-44-2863 | 1 □ M 2 🖫 = 66 | YRS. | | | March 8, 1 | | nington, D.C. |
| æ | 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | |
| DIRECTOR | 1816 Palo Circle Halethorpe Balt | | | | | | | altimore |
| REC | 10e, STATE 10b, COUNT | Y | 10c. CITY, 1 | TOWN OR LOCATIO | 10d. INSIDE CITY | | | |
| | | ltimore | | Haletho | orpe | | | LIMITS? |
| ME | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? |
| FUNERAL | 1816 Palo Circle | | | 21 | 1227 | | U.S.A. | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 NO | 13. WAS DECEN | NOENT OF HISPANI | IC ORIGIN? (Specify Yea , Puerto Rican, etc.) | or No — 14. RAC Blac | E — American Indian, ik, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | NTES 1 | | NO Specify: | Spec Whit | , | |
| ED | 15. DECEDENT'S EDU | CATION | 16e. DECEDENT'S US | UAL OCCUPATION | | INESS/INDUSTRY | rte | |
| COMPLETED | Elementary/Secondary (0-12) | (Specify only highest grade completed) (Give kind of work interpretary/Secondary (0-12) College (1-4 or 5 +) | | | of working | | | |
| MP | | 1 Homemaker Own | | | | | lome | |
| | 17. FATHER'S NAME (First, Middle, Last) | 1 | | AE (First, Middle, Maiden) | Surname) | | | |
| BE | Richard S. Paulet | | | Wilmoth | | | | |
| 5 | | | | | | oute Number, City or Town | | |
| | Dean A. Stirling | 204 | PLACE AND DATE OF | | | thorpe, Mar | | 21227 |
| | 17☐ Buriel 2 ☐ Cremetion 3 ☐ Ram 4 ☐ Donation 5 ☐ Other (Specify) | oval from State Com | etery, crematory or other | place) | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | EMBEE / | ock creek | 22. NAME AND | ADDRESS OF FAC | 25/95 Wash | | |
| | No harts | -// | ** A | | | lins Funer | | |
| | 23. PART I. Enter the diseases, or o | complications that caused | | 500 Uni | versity | Blvd.,W. | Sil.Spr. | |
| | anock, or heart failure. | List only one cause on ee | ch line. | enter the mode | e or dying, such | as cardiac or respir | atory arrest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Pancreatic Cancer | | | | | | | Onset and Death |
| | resulting in death) | a. DUE TO (OR AS A | CONSEQUENCE OF): | Ca | unce/ | | | |
| z | | | | | | | | |
| 5 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury | C | 20110501151105 25 | | | | | |
| Ē | thet initieted events resulting in death) LAST | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| | | d | | | | | | |
| AL | PART ii. Other aignificant condition | s contributing to deeth bu | at not reaulting in t | the underlying o | euse given in F | Part I. 24a. WAS AN A | | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDIC | | | | | | 1 YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| × | | | | | | - (/ | ` | 1 - YES 2 - NO |
| PHYSICIAN: | DID TOBACCO USE CONTI | | | | UNCERTAIN | | | |
| Ö | EXAMINER? | HOSPITAL: | | THER: | V | | | |
| ¥ | 27. MANNER OF DEATH | 1 Inputient 2 ER/Outpi | 28b. TIME O | | | 26d. DESCRIBE HOW IN | HIRV COCURED | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJURY | Y WORK | | 20d. DESCRIBE HOW IN | JUNY OCCUMED | |
|) BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | - At home, larm, stree | | | 281. LOCATION (Street ar | nd Number or Rural | Route Number |
| TED | 4 Homicide determined | building, etc. (Speci | (Y) | | | City or Town, State) | | |
| COMPLET | 290. CERTIFIER Check only | CIAN: To the best of my knowle | edge, death occurred a | it the time, date an | nd place, and due t | o the cause(s) and many | ner as stated | |
| NO N | | R: On the basis of exemination | | | | | | e) and manner as stated. |
| | 29b. SIGNATURE AND TITUE OF CERTIFIE | 17.1 | | 2 | 9c. LICENSE NUMI | BER | 29d. DATE SIGNED | |
|) BE | My VVoc | m h- | | | D08/1 | 8 | ▶ 8- | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | - / - |
| | 400 BEST 6 ATE | 0-0 191 | NMAPOL | 12 July | 2140 | / | | |
| | 31. DATE FILED (Month, Day, Year) | 22. HEGISTHAR'S SIGNA | TURE | | | | | , |
| | AUG 25 1995 | Tuli Davidson Ra | dall | | | | | |



| Or Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of | THE MUSH IAL OF ALLENDING PHYSICIAN, THE IAM ENGLINES THAT THE DESIGN DESIGNED WHITE A HOUR STORM STORM OF TRAINED BY THE FINSPLIA OF ALLENDING PHYSICIAN. | THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | filed within 72 hours after death with the State Degt. of Health and Mental Hygiene prior to build, cremation, or removal. | IPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| anditable do realisation and on | ID THE HUSPITAL OR ALTENDIN | TO THE FUNERAL DIRECTOR: Aft | be filed within 72 hours after dea | IMPORTANT: If Item 28 is n |

| STATE OF MARYLAND | DEPARTMENT | OF HEALTH AND | MENTAL HYGIENE |
|-------------------|------------|---------------|----------------|
| C | ERTIFICATE | OF DEATH | REG. NO. |

| REGISTRAR | | | | | | | | | | | |
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| 1. DECEDENT'S NAME (First, Middle, Las | 18) | | | | | 2. DATE | OF DEATH | AY | YEAR | 3. TIME C | OF DEATH |
| CARLOS | RICA | RDO | ŋ | TURNER | 3 | AUGI | | | | 11: | 15 1 |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | - | PLACE (St | ete or Foreign |
| 577-96-2102 | 1 📈 M 2 □ F | 2 | 4 YRS. | ONTHS DAYS | HOURS MIN. | | ch 11, | 199 | | | D. C. |
| 9a. FACILITY NAME (If not inetitution, give | e street end number) | | | b. CITY, TOWN | OR LOCATION OF | | , | | NTY OF D | | |
| PRINCE GEORGE | S HOSPITA | AL CEN' | TER | CHEV | ERLY | | | PRI | NCE | GEO | RGES |
| 10e. STATE 10b. COU | NTY | | | TOWN OR LOCA | | | | | | 10d. INSI | DE CITY |
| Wash., D. C. | | | Wash | ington | , D. C. | | | | 150 | 1 X YES | 2 NO |
| 10e STREET AND NUMBER 3634 10th Stree | t, N. E. | | | 10 | 20014 | | | 10g. CITI | | VHAT COU | NTRY? |
| 11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 X | IMED NO | If yes, s | CENDENT OF HISP pecify Cuban, Mexi S 2 NO Spec | an, Puerto I | | | 14. RACE Black | - America c, White, at my: Bla | ck |
| 15. DECEDENT'S E | | | | BUAL OCCUPATI | | 16b. | KIND OF BU | SINESS/IND | USTRY | | |
| (Specify only highest gn Elementary/Secondary (0-12) | ade completed) College (1-4 or 5 +) | 16m | live kind of wor . Do NOT use r | k done during m retired.) | ost of working | | | | | | |
| 12 | Conege (I-4 or 5+) | | udent | | | 100 | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTNER'S P | AME (First, I | Viddle, Meiden | Surname) | | | |
| Carlos Ricardo | H:11 | | | | Barbara | a Turi | ner | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING A | DDRESS (Street | end Number or Rure | / Route Numi | ber, City or Tow | vn, Stata, Zip | Code) | 7/1 | |
| Beverly Fendwic | k | | 10000 | Stroot | Gum Cir | 10 C | a remant | OLTO | ма | | |
| 20% METNOD OF DISPOSITION | | 20b. PLACE | AND DATE OF | DISPOSITION (A | lame of | DAT | E 20c. LC | CATION - | | wn, State | |
| 1 Buriel 2 Cremetion 3 R | amoval from State | cameGT & | nwood | Cemete | ry | 8/2 | 22/95 | Wash | 1., I |). C. | |
| 21. SIGNATURE OF FYSEBAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | |
| The service | LICENSEE | | | | | | | | | | |
| Ato t | FR P | 100h | , | Plunk | ett Fune | eral E | lome | | | | |
| 23. PART I. Enfer the disesses, | JB-B | Coused the de | esth. Do not | 2504 | 28th Sti | eet. | N. E. | D. C | rest, | Inte | proximate arvai Betwe |
| 23. PART I. Enfer the disesses, | B-D br complications that re. List only one count s. MUT | se on each line | 7) Bu | 2504 t enter the m | 28th Str ode of dying, su | eet. | N. E. | D. (| rest, | Inte | |
| 23. PART I. Enfer the diseases, ahock, or heart fellor immediate CAUSE (Final disease or condition | B - D or complications thete e. List only one ceus b DUE TO (| Ple ST | OUENCE OF): | 2504 t enter the m | 28th Str ode of dying, su | eet. | N. E. | D. (| rest, | Inte | rvai Betwe |
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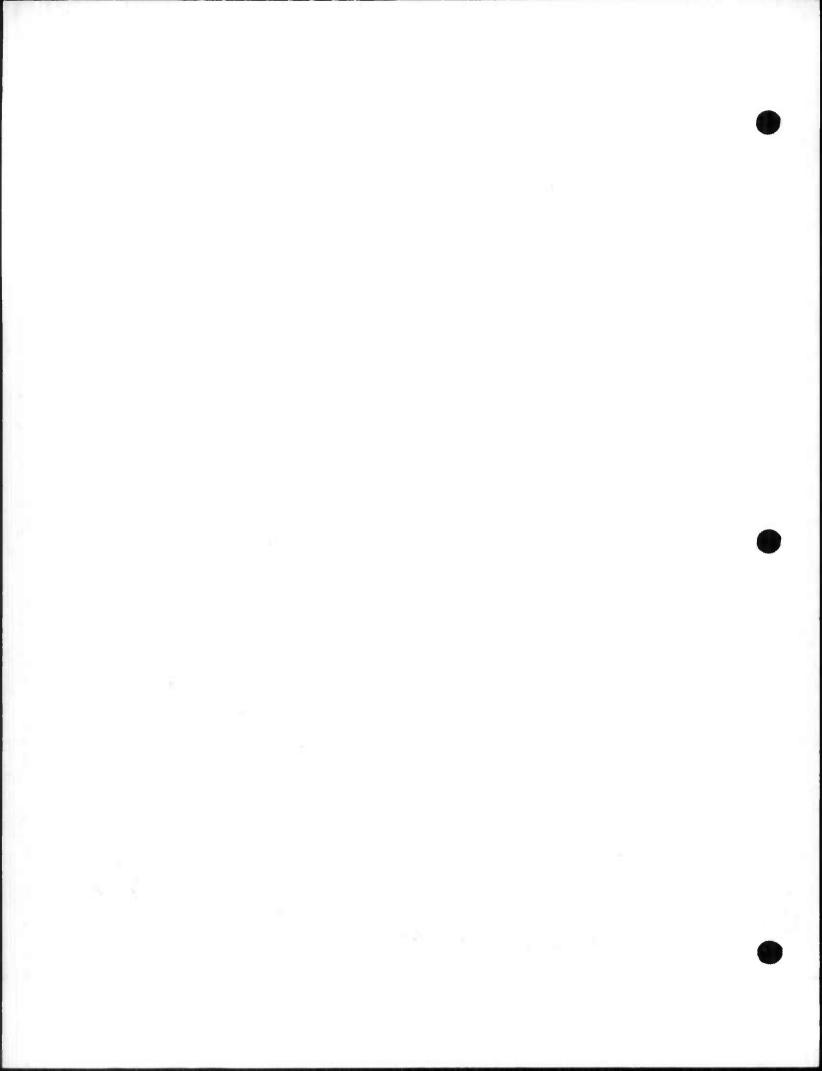


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|-------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crematio | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, th |
| 87 | cuted | 03 p | urial, | IIC B |
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| BOX 60/84 BALLIMORE, MARYLAND 21215-0020 | FENDING PHYSICIAN: The law requires that the death certificate be executed with Press after death. Page 6 may be retained by the hospital or attending physician. | OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ter death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | I a manufact as them of about before an able a bearing the manufact and the second as |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| SION OF VIEW DECONDS, P.O. DOA SO/OU | ENDING PHYSICIAN: The law requires that the death certificate be executed with | OR: After this certificate has been signed by the attending physician and completely filled in by the furter death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | O to marked as lines 22 about and fallen as ables bearings as |

| | REGISTRAR | | | CERTIF | ICALE | : OF | DEATH | - F | REG. NO. | | | | |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------|---------------------|--------------|---------------|--------------------------|----------------------------|--------------|---------------|------------|--------------------------------|-------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF MONTH | DEATH | | | 3. TIME OF | DEATH |
| | Clement | Hill | | | Ty | <i>r</i> ding | s Jr. | August | | | PAR | 1:20 | Рм |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In) | rrs. lest birthday) | IF UNDER | | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | | B. BIRTI | HPLACE (State | or Foreign |
| | 216-03-4334 | 1 🔀 M 2 🗆 F | 84 | YRS. | MONTHS | DAYS | HOURS MIN. | June | 11,19 | 911 | Mar | yland | |
| | Ba. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, | TOWN C | R LOCATION OF D | | | | INTY OF D | | |
| OR | 9820 Heatherston | e Drive | | | D 7 47 | | | | | Chai | rles | | |
| 5 | RESIDENCE OF DECEDENT | | | | | - | | | | CIRL | 1.102 | | |
| 2 | 10a. STATE 10b. COUNTY | 100. | | | | R LOCAT | ION | | | | | 10d. INSIDE LIMITS | CITY |
| ā | Maryland Charles | | | В | el Al | Lton | | | | | | 1 TYES | |
| M | 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | | | 10g. CIT | IZEN OF | WHAT COUNT | RY7 |
| FUNERAL DIRECTOR | 9820 Heatherstone | Drive | | | | | 20611 | | | | US. | A | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN FORCES? 1 | T EVER IN U. | S. ARMED | 13. V | WAS DEC | ENDENT OF HISPAI | VIC ORIGIN? (S | pecify Yes | or No- | 14. RACI | E — American k, White, atc. | Indian, |
| ВУ | 1 Never Married 2 Married 3 X Widowed 4 Divorced | IF YES, GIVE W | AR OR DATE | S | | | 2 NO Specif | | n, etc.) | | Spec | Mr. | |
| | | | | | 1 | | | | | | | White | е |
| Ī | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16 | Give kind of | work done d | CUPATIO | N st of working | 16b. KII | OF BUS | INESS/IN | DUSTRY | | |
| in . | Elementary/Secondary (0-12) | College (1-4 or 5 + | -) | life. Do NOT us | se retired.) | | | | | | | | |
| MP | 12 | | | Fa | rmer | | | | Far | ming | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | | | | 18. MOTHER'S NA | ME (First, Midd | le, Maiden S | Sumame) | | | |
| BE | Clement Hill Tydin | ngs, Sr. | | | | | Gertrud | _ | | utle | | | |
| 70 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | (Street a | nd Number or Rural | Route Number, (| City or Town | n, State, Zip | p Code) | | |
| - | Louise Ann Tucker | | | P.O. B | ox 55 | Ве | 1 Alton | Maryla | nd 20 | 0611 | | • | |
| | 20a. METHOD OF DISPOSITION | umi from State | 20b. PL | ACE AND DATE | OF DISPOSI | TION (Na | me of | DATE | 20c. LOC | CATION - | City or To | own, State | |
| | Burlei 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) Gemetery, Crematory or other place Fort Lincoln Cemetery 8-22-95 Brentwood, Mar | | | | | | | faryla: | nd | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACH ITY | | | | | | | | | | | | |
| - 3 | Robert E. Evans Funeral Home, P.A. | | | | | | | | | | | | |
| | Hobert E. Francis Property Road Bowie, Maryland 20715 23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate | | | | | | | | | | | | |
| | shock, or heart fallure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death) | Conc | ae on each | line. | iart | | Cailure | | or respir | atory ar | resit, | Interv | eximate all Between and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST | DUE TO | (OR AS A CO | DNSEQUENCE OF | ግ: | | | | | | | | |
| ij | | d. | | | | | | | | | | | |
| | PART II. Other algnificant conditions | contributing to | death but | not reaulting | n the und | derlying | cause given in | Part I. 24 | . WAS AN | | 24b | . WERE AUTOP | |
| EDICAL | | | | | | | | | PERFORI | | | AMAILABLE PE | OF CAUSE |
| | | | | | | | | _ '' | 1123 2 | X no | | OF DEATH? | |
| - | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | □ NO | | | |
| ₹ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | | | | |
| ပ္က | EXAMINER? | HOSPITAL: | | | | | 5 Residence | | | | | | |
| PHYSICIAN: M | 27. MANNER OF DEATH | 28a. DATE OF | | 28b. TIM | | ng Home | | 8 Other (Sp 28d. DESCRI | | Milmy no. | | | |
| | Natural 5 Pending | (Month, Di | | INJ | URY | WO | RK? | 280. DEŞÇMI | BE HUW IN | JURY OC | CURED | | |
| à | 2 Accident Investigation | 28a PLACE OF | E IN HIDV | At home form | | 1 U Y | | - | | | | | |
| | 3 Suicide 4 Homicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Stelle) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Stelle) | | | | | | | | | | | | |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYSIC | JAN: To the best of | my knowledg | pa, death occurre | d at the tir | ne, data | and place, and due | to the cause/s |) and many | ner an afet | led. | | |
| 8 | (MEDICAL EXAMINER | | | | | | | | | | |) and manner | an stated. |
| | 29b. SIGNATURE AND TITLE OF CENTURALS | Mal | | | | | | | | | - | | |
| BE | 1 ! MIIII | | | | | | D /6/10 | RER | | 29d. DAT | ESIGNED | (Month, Day,) | Sar) |
| ၉ | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALL | E OF DEATH | (ITEM AT ~ | Dela 1 | | D-46419 | | | | 0/2 | 0/0- | |
| | | | E OF DEATH | (ITEM 27) (Type, | 7 | 00 0 | ld Line Ce rf, Maryla | nter,Sui | ite 10 | 0 | | | |
| | Charlene Letchford, 31. DATE FILED (Month, Day, Year) | | Pici cioni am | 4 | W | aldo | rt, Maryla | nd 20602 | 2 | | | | |
| | AUG 25 1995 | SE REGISTRA | U SIGNATU | artall | | | | | | | | | 1 |



TIMORE, MARYLAND 21215-0020

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | PITAL OR ATTENDING PHYSICIAN: |
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| cal examiner must be notifi | |
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| nows any injury, or other | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TEPTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State begin. Of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| ΓE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE |
|--------|-------------------------------------------------------------|
| ISTRAR | CERTIFICATE OF DEATH REG. NO. |

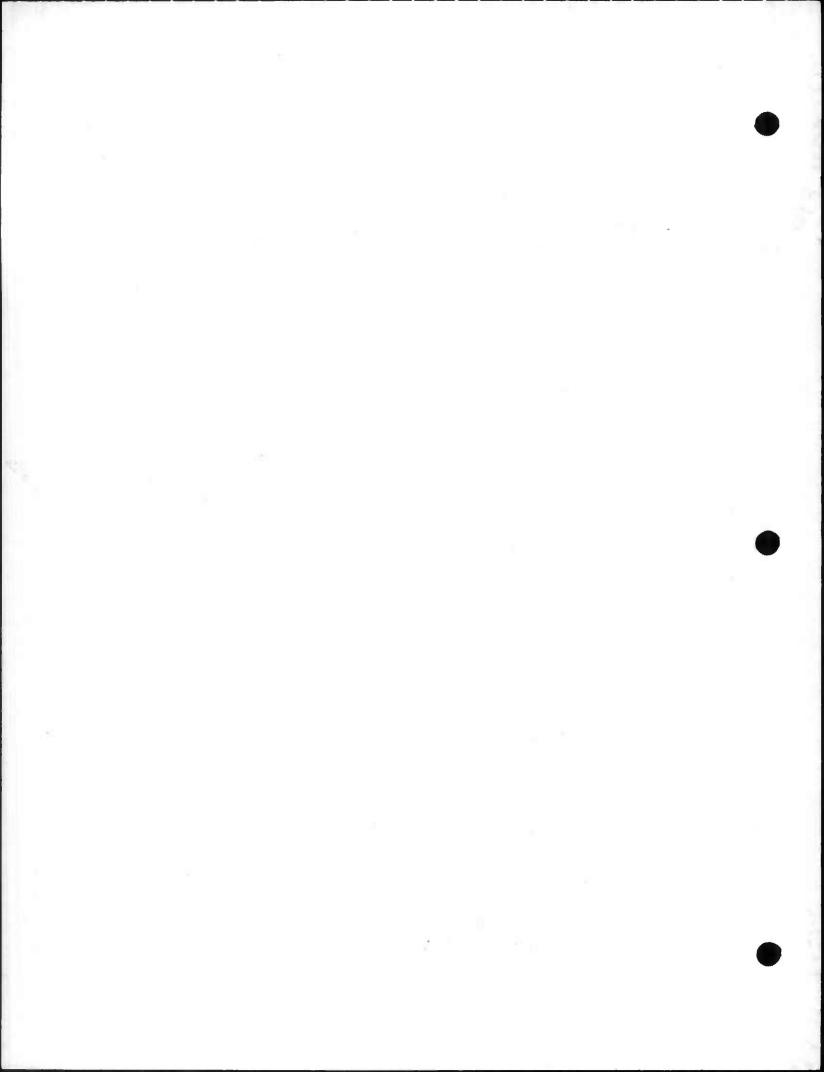
| | 1 - FOR STATE REGISTRAR | STATE OF MARY | | | HEALTH AND F DEATH | MENTAL HYGIEI | | | | |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------|----------------------------------|-----------------------------------------------------------|--------------------------------------------------|-----------------|--------------------------------------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Wilbert | | | Taylor | | 2. DATE OF DEATH MONTH AUGUST 22,1 | | 3. TIME OF DEATH 9:50 P | | |
| | 220 32 6654 | X M 2 D F | E (In yrs. last birthday) 5 9vrs. | IF UNDER 1 YEAR | | 7. DATE OF BIRTH | 8.8 | HITTNPLACE (State or Foreign PLATA, MD. | | |
| DIRECTOR | 90. FACILITY NAME (If not institution, give stree Physicians Memorial Hornestone of Decement | | | La Plat | OR LOCATION OF I | DEATH | Charles | | | |
| EC | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LO | CATION | | | 10d. INSIDE CITY | | |
| | MARYLAND CH | ARLES | LA | PLATA | 101. ZIP CODE | | Tan artism | 1 XYES 2 NO | | |
| FUNERAL | 7821 BUMPY OAK R | | | | 20646 | | U.S.A | | | |
| В | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER FORCES? 1 — YES IF YES, GIVE WAR OR | 3 2 NO | If yes, | ECENDENT OF NISPA specify Cuben, Mexic ES 2 NO Spec | ANIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | 1 3 | RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12) | TION mpleted) College (1-4 or 5+) | Ille. Do NOT us | vork done during ne retired.) | TION most of working | | JSINESS/INDUSTI | | | |
| MP | 17. FATHER'S NAME (First, Middle, Last) | | D12 | ABLED | | N/A | | | | |
| BE CC | | YLOR | | | EDITH | V. WAT | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | | | Route Number, City or Tox | | | | |
| _ | EDITH V. TAYLOR 7821 BUMPY OAK RD., LA PLATA, MD. 20646 | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or other place) ST. JUSEPH CATH. CH. CEMETERY 20c. LOCATION — City or Town, State 8/26/95 POMFRET, MARYLAND | | | | | | | | | |
| | 21. SIGNATURE OF TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY E.M. DUDLEY FUNERAL HOME | | | | | | | | | |
| | 3200 R.I.AVE., MT. RAINIER, MD. 20712 | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heert failure. List only one cause on each line. Approximate interval Batween | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | |
| | | DUE TO (OR AS | A CONSEQUENCE OF | 7): | 0 | | | | | |
| NO. | Sequentially list conditions, | DUE TO (OR AS | A CONSEQUENCE OF | 7): | | | | | | |
| 8 | If any, leading to immediata cause. Enter UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | | | | | | | | | |
| | d | | | | | | | | | |
| PHYSICIAN: MEDICAL | Hirtory wascular turner remend from PERFORMED? | | | | | | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| Σ | DID TOBACCO USE CONTRIB | LITE TO CALISE (| OF DEATH VE | C D NO | T INCEPTAL | | | 1 - YES 2 -40 | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | OTE TO CAUSE (| 26. PLACE OF DEAT | | | иП | | | | |
| SIC | | OSPITAL: | | OTHER: | | 8 Other (Specify) | | | | |
| μ̈́ | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIMI | E OF 28c. I | NJURY AT | 28d. DESCRIBE HOW | INJURY OCCURE | D | | |
| BY F | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJ | | YES 2 NO | | | | | |
| 0 | 2 Accident 3 Suicide 8 Could not be determined 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAL (CHECK ONLY ONE) DEDICAL EXAMINER: C | N: To the best of my known on the besis of examination | wiedge, death occurre on and/or investigation | d at the time, de | te and place, and du | e to the cause(e) and ma | nner se stated. | se(s) and manner as stated, | | |
| BE C | SHE SIGNATURE AND TITLE OF CERTIFIER | 1.1.11 | toman | | 29c. LICENSE NU | MBER | | NED (Month, Day, Year) | | |
| 2 | TO NAME AND ADDRESS OF STREET | - recent | | | D-08370 |) | D 81 | 23195 | | |
| , | 30. NAME AND ADDRESS OF PERSON WHO CO Paul Pritchett Sr, MD 1 | | | | La Plata. M | ld. 20646 | | | | |
| | AUG 25 1995 | 32 AFGISTHAN'S SIG | MATURE COLL | | | | | | | |

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | NT OF HEALTH AND | MENTAL HYGIEN | E | | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------|-------------------------------------------|------------------|--------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | OF BEATT | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | Henderson | Woodrow Tu | chen. | | August 15. | 1995 YEA | | | | |
| | 4. SOCIAL SECURITY NUMBER 5 | SEX 6. AGE (| In yrs. last birthday) IF U | IDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 0. Bt | RTHPLACE (State or Foreign | | | |
| | 403-20-0483 t 9e. FACILITY NAME (If not institution, give stree | t and number) | | HE DAYS HOURS MIN. | | 0.00 | entucky | | | |
| DIRECTOR | Doctor's Community | | | anham | | | George's | | | |
| 360 | 10s. STATE 10s. COUNTY | | 10c. CITY, TOV | /H OR LOCATION | | | 10d. INSIDE CITY | | | |
| | Maryland Prince | George's | Lank | | | | 1 YES 2 NO | | | |
| FUNERAL | 9211 5th Street | | | 10f. ZIP CODE | | | F WHAT COUNTRY? | | | |
| 2 | | 2. WAS DECEDENT EVER IN | III S ARMED | 20706 13. WAS DECENDENT OF HISP | NIC OBIGINS (Seconds Ven | | d States | | | |
| BY FL | 1 Never Married 2 Married 3 Widowed 4 Divorced | | 2 NO | If yes, specify Cuban, Mexi | can, Puerto Rican, atc.) | В | leck, White, etc. White White | | | |
| G | 15. DECEDENT'S EDUCAT | | 16a. DECEDENT'S USUA | L OCCUPATION | 16b. KIND OF BUS | INESS/INDUSTR | | | | |
| ᇤ | (Specify only highest grade con Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work do | one during most of working ad.) | | | | | | |
| MPI | 12 | | Machinist | | Aerody | namics | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | 18. MOTHER'S | AME (First, Middle, Maiden | | | | | |
| BE | Glenny Dale Tucker | | | Moma | LeGrand | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | IESS (Street and Number or Rura | | | | | | |
| | Audrey Tucker | | | h Street, La | | | 706 | | | |
| | 20a. METHOD OF DISPOSITION 1 VI Buriet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cremetory or other place) DATE 20c. LOCATION — City or Town, State | | | | | | | | | |
| | 4 Donetton 5 Other (Specify) Fort Lincoln Cemetery 8/18/95 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| | · Daim | Dut | - 1 | Fort Lincoln 3401 Bladens | Funeral Hor | ne, Inc | d, MD 20722 | | | |
| | 23. PART 1. Enter the diseases, or com | nplicatione thet ceused | the death. Do not er | iter the mode of dying, su | ch as cardiac or respi | ratory arreat, | Approximate | | | |
| İ | shock, or heart fellure. Lis | t only one cause on ea | ich line. | | | | Onset and Death | | | |
| | disease or condition resulting in death) | Hy Note | wim | | | | 12hrs | | | |
| | | DUE O (OR AS A | CONSEQUENCE OF): | | | | | | | |
| 2 | Sequentially list conditions, b. | Lung C | WCINDMO | | | | 144 | | | |
| Ĕ | If any, leading to immediate cause. Enter UNDERLYING | DUE ID (OR AS A | CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury C. | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| ᇎᅵ | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | |
| 빙 | 0 | | | | | | | | | |
| ¥ | PART II. Other significent conditions of | //() 8 | | underlying cause given i | Part I. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | |
| MEDIC | Diabetes rellets. | | | | | | COMPLETION OF CAUSE OF DEATH? | | | |
| | | | | | | | T YES 2 NO | | | |
| CIAN | DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL | | F DEATH YES E | | IN L. | | | | | |
| | | OSPITAL: | OTI | IER: | | | | | | |
| BY PHYS | 27. MANNER OF DEATH | 28s. DATE OF INJURY | 28b, TIME OF | Nursing Home 5 Residence 28c. INJURY AT | 6 ☐ Other (Specify) 28d. DESCRIBE HOW th | LIURY OCCURED | | | | |
| م ح | Netural 5 Pending trivestigation | (Month, Day, Year) | INJURY | WORK? | | | | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be | 28a. PLACE OF INJURY | — At home, term, street, | factory, office | 281. LOCATION (Street a | nd Number or Rur | al Route Number, | | | |
| G | 4 Homicide detarmined building, stc. (Specify) | | | | | | | | | |
| - 1 | 4 Homicide determined | 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| PLET | 29a. CERTIFIER CERTIFYING DAYSICIA | N: To the best of my knowl | edga, death occurred at t | he time, date and place, and de | e to the cause(s) and man | ner as stated. | | | | |
| OMPLET | 29a. CERTIFIER CERTIFYING PHYSICIA | | | he time, date and piece, and do my opinion, death occured at th | | | e(s) and menner as stated. | | | |
| E COMPLET | 29a. CERTIFIER CERTIFYING PHYSICIA | | | | e time, data and placa, an | dua to the caus | e(s) and menner as stated. | | | |
| BE | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | | | ny opinion, death occured at th | e time, data and placa, an | dua to the caus | | | | |
| w l | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | On the basis of axamination | and/or investigation, in r | py opinion, death occured at the 29c. LICENSE N | e time, data and placa, an | dua to the caus | | | | |
| BE | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: (29b. SIGNATORE AND TITLE OF CERTIFIER | On the basis of axamination | ATH (ITEM 27) (Type, Print) | ny opinion, death occured at th | e time, data and placa, an | dua to the caus | | | | |



TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Amended # 1 8-22-95
TMT Talbot Co.

| 1 - STATE REGISTRAR | OTHE OF INTHIT | | CATE OF | DEATH | WENT IN | REG. NO |). | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------|------------------------------------------------------|-------------------|------------|---------------------|------------------------------------|-------------------------------------------------------------------------|
| 1. OECEDENT'S NAME (First, Middle, Last) | | | - | | 2. DATE | OF DEATH | DAY . | YEAR 3. | TIME OF DEATH |
| A. E. THORN | 10010 6 | vans 11 | 10rn | | 08 | | 95 | 3 | 3:06 A.M. |
| 4. SOCIAL SECURITY NUMBER | Constant Con- | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE (Mont) | OF BIRTH | | Country) | CE (State or Foreign |
| 578-03-8441 | | YAS. | | | | 13, | _ | GEOR | |
| 9a. FACILITY NAME (If not institution, give | | | | OR LOCATION OF C | MEATH | | | Y OF OEATI | |
| WILLIAM HILL RESIDENCE OF DECEDENT | MANOR | | EAS' | ron | | | TALBOT | | |
| 10e. STATE 10b. COUNT | Y | 10c, CITY, | TOWN OR LOCA | TION | | | | 100 | 1. INSIDE CITY |
| MARYLAND | TALBOT | | EASTO | N | | | | X | LIMITS? |
| 10e. STREET AND NUMBER | | • | 10 | f. ZIP CODE | | | 10g. CITIZE | N OF WHAT | COUNTRY? |
| 501 DUTCHMAN' | S LANE | | | 2160 | 1 | | US | A | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12, WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR | 2 NO | If yes, s | CENOENT OF HISPA Hecity Cubert, Mexic NO Speci | an, Puerto | | e er No— | 4. RACE — Black, Wi Specify: | American Indian, hita, atc. WHITE |
| 15. OECEOENT'S EO | ICATION . | 16a. OECEOENT'S L | JSUAL OCCUPATI ork done during m | | 16b | KIND OF BU | JSINESS/INDU | STRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | or working | | | | | |
| 11 | | HOMEMA | AKER | | | | HOME | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N | | | 2932012.2 | | |
| LUCIUS OTTMAR | EVANS | | | | CARI | | HODO | | |
| 19a. INFORMANT'S NAME (Type/Print) | ON | | | and Number or Rural | | | | - | 21401 6 |
| JANE T. MOULT | | 0b, PLACE AND OATE | | | OAT | - | OLIS, | | 21401-6 |
| 26a, METHOO OF DISPOSITION 1 | noval from State | ALISBURY | | | 8-21 | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| M.E. News | Man ! Ho | CFSP | | AM FUNE S. HARF | | | - | | MD |
| 23. PART I. Enter the diseases, or shock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause on | | lisease | | | | | | Approximate Interval Betwee Onset and Deat LZ4LL |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | е | A CONSEQUENCE OF | | | | | | | |
| PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Particular in Sufficiency | | | | | n Part I. | | N AUTOPSY DRMED? | CO OF | RE AUTOPSY FINDINGS AILABLE PRIOR TO MIPLETION OF CAUSE DEATH? |
| | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | JUGGS 11 | QTHER: | LACE OF DEATH (C | | | | | |
| 1 🗌 YES 2 NO | 1 Inpatient 2 ER/Ou | | 4 Nursing Ho | me 5 Residence | | | IN HIRV OCC | IDEO. | |
| 286. DATE OF INJURY (Month, Day, Year) 286. INJURY 286. INJURY AT WORK? Notural 5 Pending 286. DATE OF INJURY 286. INJURY AT WORK? M 1 YES 2 NO | | | | | | | | | |
| 2 Accident Investigation 28e PLACE OF INJURY — At home, farm street factory office 281 LOCATION | | | | | | | t and Number of | r Runal Rout | e Number, |
| 3 Suicide 6 Could not be datermined 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | | |
| CONDON ONLY | SICIAN: To the best of my kno | | | | | | | | nd manner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFI | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) | | | | | | | | |
| MDC | ER , | (AX) | | 29c, LICENSE N | UMBER | | 29d. DATE | SIONED (M. | onth. Day, Year) |
| / / . //. | rowley, M | D PASO | Two | 29c. LICENSE N | 543 | 3 | 29d. DATE | 3.ZO | onth, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF I | DEATH (ITEM 27) (1950, | Print) Are | DZ | 593 | m, N | ▶ 8 | 3.20 | onth, Day, Year) 95 |
| 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF 1 | Idlewit. | TND Print) Ave | DZ | 593 | m, N | ▶ 8 | 3.20 | onth, Day, Year) • 95 |

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| PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the I | 2 | |
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| 2 | JR: After this certificate has been signed by the attendin | P. |
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| 9 | E | Poli |
| TAL OR ATTENDING PH | M | 72 hours after death with the State Dent of Health and M. |
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| | | | | | - | à | | | | | 95 | 5 2 | 7229 |
|-----------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------|-----------------|------------------|----------------------------------|-------------------------|-----------------|-------------------------------------------------|-------------------|--------------------|--------------------------------------------------------------------------------|
| | | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR | TMEN' | T OF H | EALTH DEAT | AND I | MENTAL HYGIE | | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | - | | 2. DATE OF DEATH MONTH | DAY | VEAD | 3. TIME OF DEATH |
| | 1 | | iorgis | | | Taylo | r | | | Aug 2 | 5 | 1995 | 1:08 A: M |
| - | | 4. SOCIAL SECURITY NUMBER 517-12-0755 | 5. SEX | 6. AGE (In yrs. las | YRS. | MONTHS | DAYS | IF UNDER | 24 HRS. MIN. | June 13 | ,192 | a. BIRTHE | Montana |
| 2, 3 should | _ | 9a. FACILITY NAME (If not institution, give : | treet and number) | | | 9b. CIT | , TOWN O | R LOCATIO | N DF DE | ATH | 9c. CO | UNTY OF DE | ATH |
| 23 | TOF | Physicians Memorial | Hospital | | | | LaPla | ata | | | | Char | les |
| physician. burial-transit permit. Pages 1, | DIRECTOR | 10a. STATE 10b. COUNT | harles | | | | or Locat | ЮН | | | | | 10d. INSIDE CITY LIMITS? |
| ermit. | | 10a, STREET AND NUMBER | | | | | 101. | ZIP CODE | | | 10g. Cr | | 1 YES 2 NO |
| n. ansit p | ER, | 11600 Farm Dri | ve | | | | | 206 | 646 | | | U.S | Δ |
| | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 🔀 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 A | MED 10 | | WAS DECI If yes, spe 1 YES | ENDENT O | F HISPAN | NC ORIGIN? (Specify) n, Puerto Rican, atc.) | es or No— | 14. RACE Black, | - American Indian, White, atc. |
| or attending ir use as the | E | 15. DECEDENT'S EDU (Specify only highest grade | | 16a, DE | CEDENT'S | USUAL O | CCUPATIO | N It of working | | 16b. KIND OF B | USINESS/IN | DUSTRY | |
| | É | Elementary/Secondary (0-12) | College (1-4 or 5 + | -) IIIo. | Do NOT us | se retired.) | | | | Housi | 2 ~ 6 | IInch | on Daniel |
| the hospital detached for once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | 2 | Con | trac | et S | pec | iali | | | | | an Develo |
| - | S S | John B. Giorgis | | | | | | | | WE (First, Middle, Meidle | | | 7 |
| 5 should | 00 | 19e. INFORMANT'S NAME (Type/Print) | ' | 198 | b. MAILING | ADDRES | S (Street ar | | | ta Bell | | | gls |
| be retained by ge 5 should be a notified at | 임 | George B. Taylo | r | 1 | 1600 |) Fa | rm | Dr. | LaP | lata.MD | 206 | 46 | |
| | | 20a. METHOD OF DISPOSITION 157 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | 20b.PLACEA | math y | of pispos | em. | me of | | | | | rn, Stata D |
| hours after death. Page 6 may ed in by the funeral director, pa, or removal. medical examiner must b | | 21. SIGNATURE OF FUNERAL SERVICE LIC | Chal | M009 | 45 | ² A | REAL | ART [©] Box | ECH 56 | OLS FUN 7 LaPla | ERAL ta,M | HOM D 200 | E, INC. 646 |
| within 24 npletely fill cremation rent, the | | 23. PART i. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finei disease or condition resulting in death) | List only one cau | t ceused the da se on each lina OH AS A CONSEC | Su | n | the mod | an of dyle | M such | as cardiac or res | piratory a | D. | Approximate interval Between Onset and Death |
| ath certificate be executed by sician and tall Hygiene prior to but or other traumatifit, or other traumatifity | SERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | · Ro | (OR AS A CONSEC | ha | m | ~ | | 2 | V | | - 1 | \$ |
| that the ded by the th and Mea | EDICAL (| PART II. Other significant condition | s contributing to | death but not re | esulting | in the ur | derlying | cause g | iven in I | | DIMED? | | WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| w requires been sign pt. of Heal 3 shows | M .: | DID TOBACCO USE CONTI | RIBUTE TO CA | USE OF DEA | TH YE | s 🗆 I | NO 🗆 | UNC | ERTAIN | | | | 1 D YES 2 D HO |
| t: The law cate has 1 State Dept | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | E OF DEAD | TH (Check | only one) | | | | | | |
| SIAN: intification be State | YSI | 1 ☐ YES 2 NO AO | 1 inpetient 2 | ER/Outpatient 3 | □ DOA | 4 D Nur | | S 🗆 Res | sidence (| 6 C) Other (Specify) | | | |
| NG PHYSIC fler this ce sath with the | ВУ РН | 27. Manual of Clearin Natural of Penning Investigation | 28e. DATE OF (Month, De | | 26b. TIM INJ | E OF URY M | 1 V | WC7 | NO | 384. DESCRIBE HOW | INJURY OC | CURED | |
| CTOR: Att | 9 | 3 Suitside 6 Could not be 4 Homicide determined | 28s. PLACE OF building. | F INJURY — At horetic, (Specify) | me, term, s | dreet, fact | ory, uffice | 2 | | 281. LOCATION (Street City or Reart, State | r and Numbe e) | er ar Rusel Ro | suite Number; |
| DSPITAL OR / INERAL DIRE Thin 72 hours INT: If Item | COMPLE | | | | | | | | | to the cause(a) and m | | | and menner as stated. |
| TO THE HOSPI TO THE FUNEF DE SIED WITHIN | D BE | 296. SIGNATURE AND TITLE OF CERTIFIED | M | Ly | | 1 | | 29c. LICEI | NSE NUM | | 29d. DA | S 2 | Month Day, Year |

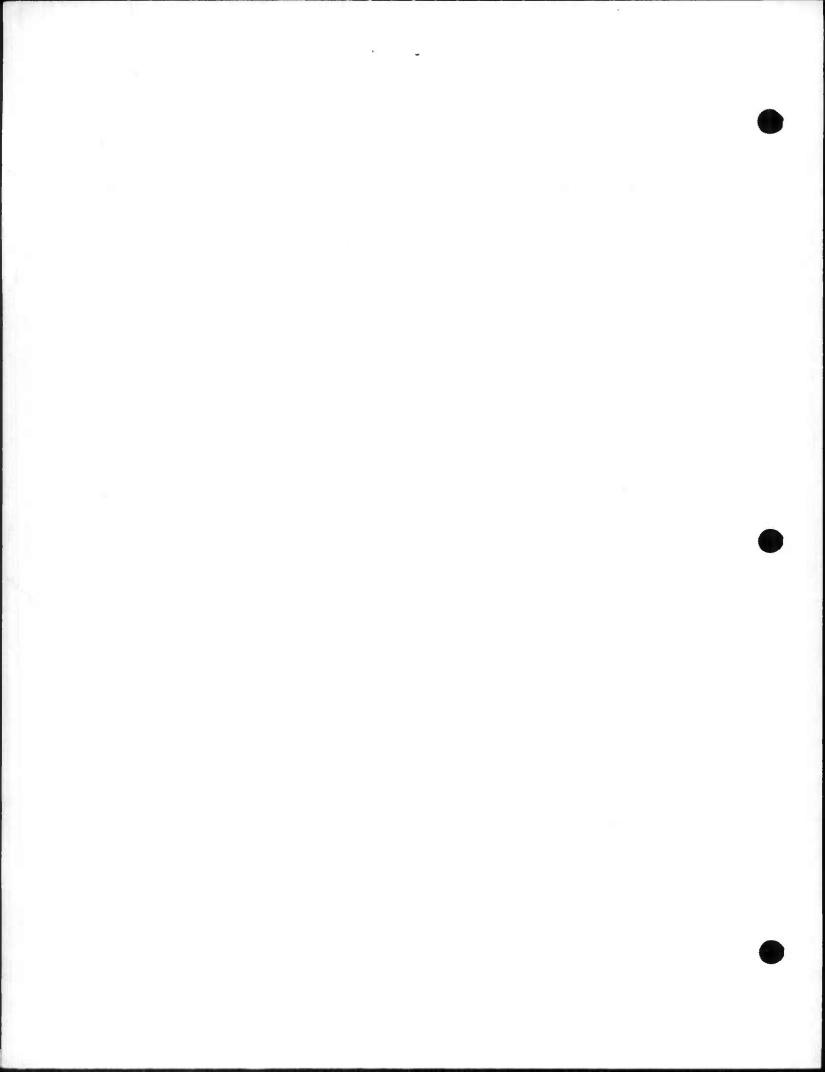
F PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type

George Wathen MD 11345 Pembrooke Square Suite 104 Waldorf Md. 20603

31. DATE FILED (Month, Surf. Vest)

AUG 2 8 1995

Julia Michigan Randall



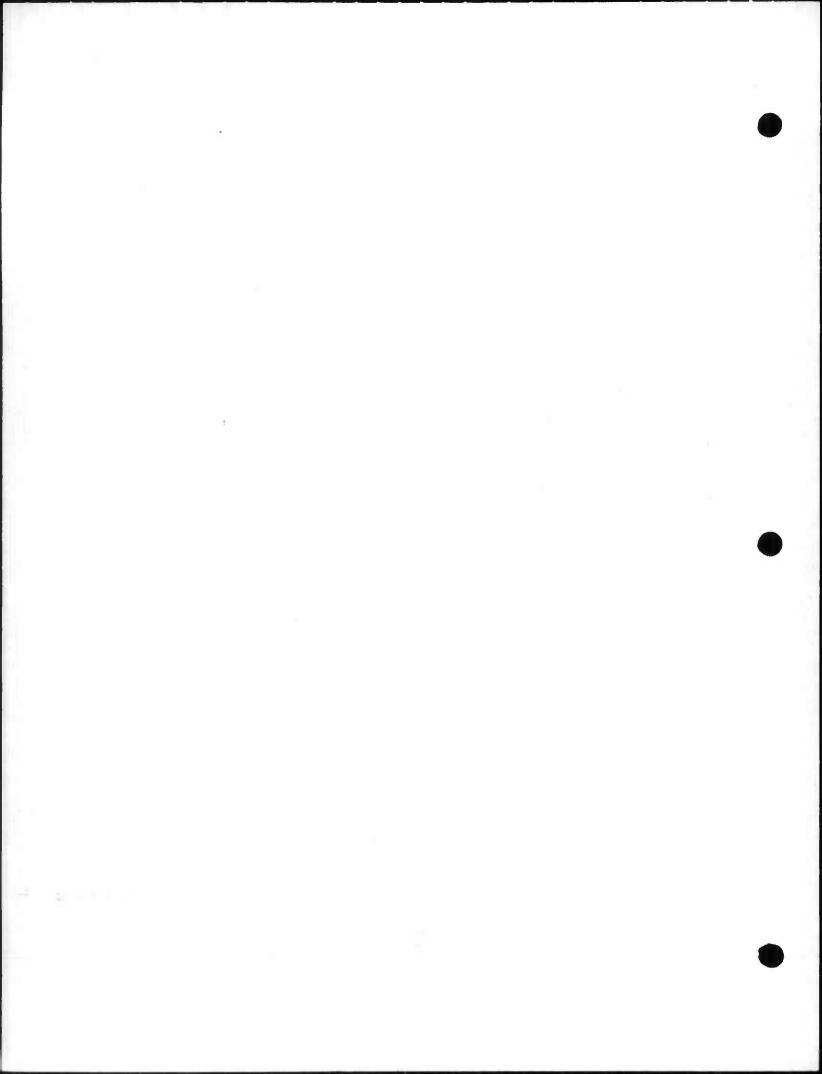
th. Page 6 may be retained by the hospital or attending physician. neral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68750

| DALLIMORE, MARTLAND | nours after death. Page 6 may be retained by the hosp | d in by the funeral director, page 5 should be detached | or removal. | medical examiner must be notified at once. | |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| DISSION OF VITAL RECORDS, F.O. BOA 88/80 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within = hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| ŀ | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATN | | 3. TIME OF DEATH |
|---|------------------------------------------|-------------------------------------------------------------------|----------------------------|----|------------------|
| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | | |
| | | | | 95 | 27230 |

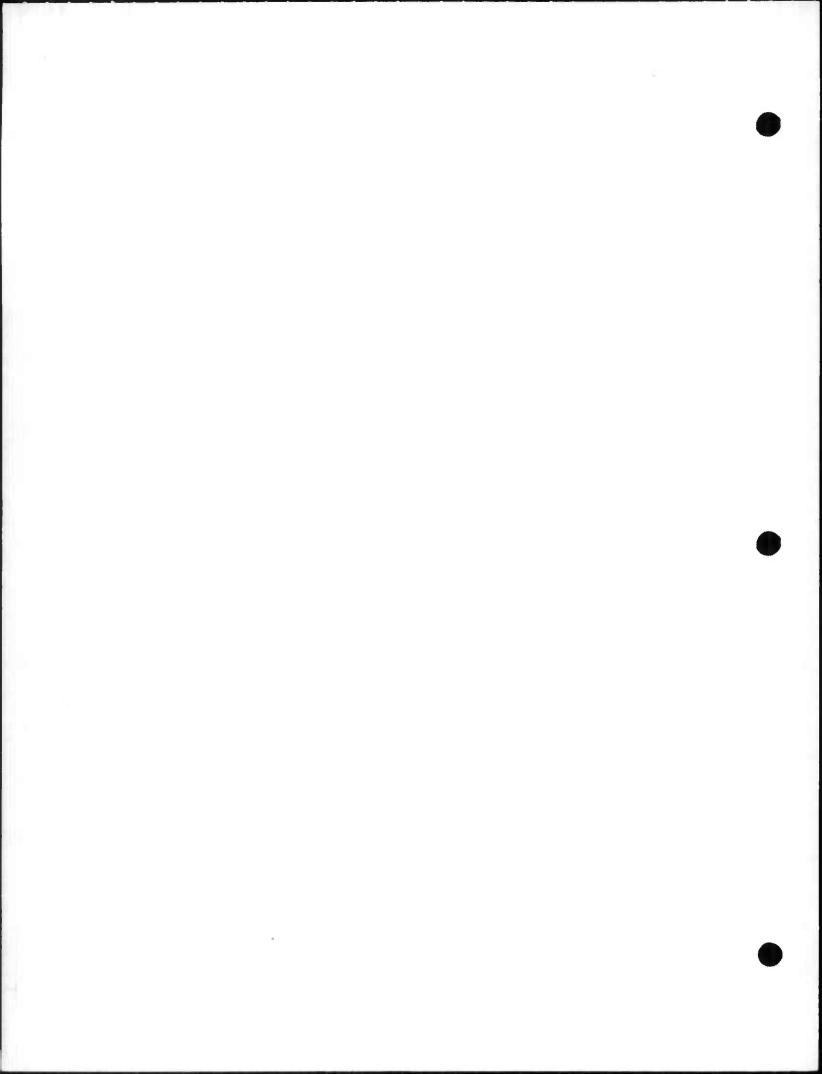
| | 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | | 2. DATE OF | | | | 3. TIME OF DEATH |
|---------------|--------------------------------------------------|------------------|------------------------------|-------------------|---------------|------------------|------------|------------------|-------------|------------------------|----------------|---------------|------------|----------------------------------------|
| - 7 | Fr | ancis | Samuel T | alerico |) | | | | | Aug. | 27. | 1995 | YEAR | 6:35 P. M |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 8. AGE (In yrs. I | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | BJRTH | | 8. BIRTH | IPLACE (State or Foreign |
| | 207-05-0106 | | 1 XM 2 F | 79 | YRS. | MONTHS | DAYS | HOURS | MIN. | Apr. | 79, 1 | 1916 | Count | a. |
| ~ | 9s. FACILITY NAME (If not in | | | | | 9b. CITY | | OR LOCATI | | | | | NTY OF D | |
| 2 | Frederick M | | l Hospit | al | | |] | Frede | rick | | | Fr | eder | rick |
| <u>n</u> | 10s. STATE | 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN (| OR LOCA | TION | | | | | - | 10d. INSIDE CITY |
| DIRECTOR | Md. | F | rince Ge | orges | Su | uitla | ind | | | | | | | LIMITS? |
| A | 10s. STREET AND NUMBER | 8 | | | | | 10 | f. ZIP COD | _ | | | | | WHAT COUNTRY? |
| FUNERAL | 3861 St. | Barnab | as Rd. | | | | | 2074 | 16 | | | U | J.S.A | |
| 2 | 11. MARITAL STATUS 1 Never Merried 20 | Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. A | | | | | | IC ORIGIN? (S | | or No- | 14. RACE | E — American Indian, k, Whits, stc. |
| B | 3 Widowed 4 Divo | _ | IF YES, OIVE W | WAR OR DATES | | | | 2 X NO | | | ,, | | | hite |
| COMPLETED | 15. DEC (Specify onl) | EDENT'S EDU | CATION completed) | 16a. D | ECEDENT'S | USUAL O | CCUPATI | ON . | | 16b. KII | ND OF BUS | SINESS/IN | | |
| 9 | Elementary/Secondary (0 | | College (1-4 or 5 | +) # | lu. Do NOT u | se retired.) | | Jat Or World | 70 | | | | | |
| M | 9 | | | r | efini | sher | | , | | | urni | | co. | |
| | 17. FATHER'S NAME (First, M Samuel Ta | . , | | | | | | | | ME (First, Middle Lov. | | Sumame) | | |
| BE | 19a, INFORMANT'S NAME (1 | | | | Ob. MAII INC | ADDRES | Ctmat. | | | loute Number, | | | | |
| 2 | Lorraine | | erico | | | | | | | , Sui | | | | 0746 |
| | 20e. METHOD OF DISPOSIT | ION | | | ANDDATE | OF DISPOS | ITION (N | ame of | , na | DATE | _ | CATION — | | |
| | 1 Donation Donation | | oval from State | Smit | hsbur | ther place) | ema | tory | | 8/28 | | thsbu | | |
| - 1 | 21. SIGNATUSÉ OF FUHERA | L BEHVIDE LIC | ENSEE | | | | | ND ADDRE | | | | | | |
| | */Wale | 3011 | orpon | _ | | Dc 31 | nale E. | d B. Mair | Thom St. | pson , Mid | Fune: dleta | ral b own. | Md. | 21769 |
| | 23. PART I. Enter the di ahock, or h | iseasea, or c | omplications the | t caused the d | eeth. Do | not enter | the mo | de of dy | ing, auch | as cardiac | or reapl | ratory ar | reat, | Approximata |
| | IMMEDIATE CAUSE (FIR | | • | | | | | | | | | | | Interval Batween Onset and Death |
| - 1 | disease or condition resulting in death) | → , | n | mania | | | | | | | | | | 1 1111 |
| _ | | | | (OR AS A CONSE | EOUENCE O | F): | | | | | | | | 1 416 |
| <u>é</u> | Sequentially list conditi | | DUE TO | (OR AS A CONSE | OUENCE OF | F): | | | | | | | | |
| 3 | cause. Enter UNDERLY! | ING | c. | | | | | | | | | | | |
| | that initieted eventa resulting in desth) LAS | | DUE TO | (OR AS A CONSE | EOUENCE OF | F): | | | | | | | | |
| CERTIFICATION | resulting in desth) LAS | | d | | | | | | | | | | | |
| - 4 | PART II. Other significe | nt condition | a contributing to | deeth but not | resulting l | n the ur | derlyln | g ceuse g | given in | Part I. 24 | . WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| DICAL | | | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | | | | | OF DEATH? |
| z | DID TOBACCO U | SE CONTR | RIBUTE TO CA | USE OF DEA | ATH YE | s 🗆 ı | NO [| UNC | ERTAIN | 13 | | | | 4.1 |
| SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | 28. PLA | CE OF DEAT | OTHER | | | | | | | | |
| N N | 1 TYES 2 NO | | 1 / Inpetient 2 | | | 4 🗌 Nun | sing Hom | | aldencs | 0ther (S | pecify) | | | |
| PHY | | Pending | 28s. DATE OF (Month, D. | | 28b. TIM | E OF URY M | armone. | URY AT PRICE 2 [| ON | 26d. DESCRI | BE NOW II | NJURY OC | CURED | |
| | 2 Cutotde | Could not be | 28e, PLACE O | F INJURY — At b | ome, term, a | rtrset, tsct | | | | 28f. LOCATIO | N (Street e | ind Number | or Rural A | loute Number, |
| | | determined | bunding, | etc. (Specify) | | | | | | City or To | wn, State) | | | |
| | 29s. CERTIFIER (Check only | IFYINO PNYSI | CIAN: To the best of | my knowledge, d | eath occurre | d at the t | lme, data | and place, | end due | to the cause(s |) and man | ner as stat | led. | |
| COMPLET | | | | | | | | | | | | | |) and menner es stated. |
| BEC | 29b. SIGNATURE AND TITLE | / | | | | | | 29c, LICE | NSE NUM | BER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 0 | | 799 | - mo | | | | | DI | 693 | 9 | | • | 9/1 | 195 |
| - | 30. NAME AND ADDRESS OF | F PERSON WNO | COMPLETED CAUS | SE OF DEATH (ITE | EM 27) (Type, | | | | 1 | | | - | 1 | |
| | Dr Michae | -1 1% | he Po | 1.80X1 | | NIG | 9/6 | tow | n. | ND | 21 | 169 | | |
| | SEP 0 | | 32. REGISTRA | RS SIGNATURE | Carlo 12 | | | | | | | | | |
| | JLI U | T 1999 | 0 | | | | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

| 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | | HYGIENE REG. NO. |
|------------------------------------------|-------------------------------------------------------------------|------------|---------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF | OEATH |

| | 1.1 | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | • | 2. DATE OF OEATH | | | 3. TIME OF DEATH |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------|--------------------------------|---------------------------------|---------------|-------------|---------------------|------------|-------------------------------------------------|-------------|------------|-------------------------------------------|
| | 8 | Elizab | eth | Marga | ret | To | wnsen | d | | | August 17 | | YEAR | 11:05 AM |
| | | 4. SOCIAL SECURITY NUMB | ER | 5. \$EX | | rs. last birthday) | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | , 199 | A. BIRTH | PLACE (State or Formion |
| | - 5 | 578-52-470 | 7 | 1 🗆 M 2 🔀 F | 9, | 4 YRS. | MONTHS | DAYS | HOURS | MIN. | Sept. 3, | 1900 | Countr | York |
| should | | 9a. FACILITY NAME (If not in | stitution, give st | reet and number) | | | 9b. CITY | TOWN C | OR LOCATIO | ON OF DE | | _ | NTY OF D | |
| 2, 3 | CTOR | Sacred Hea | rt Hom | e, Inc. | | | Нуа | tts | /ille | | | Pr | ince | George |
| | [W] | RESIDENCE OF DEC | 10b. COUNTY | , | | 100 CV | ry, town (| OR LOCAT | 101 | | | | | |
| 200 | DIR | Maryland | | ce Georg | .0 | | yatts | | | | | | 1 | 10d. INSIDE CITY LIMITS? |
| ermit. | 127 | 10e. STREET AND NUMBER | 1111 | ice deorg | <u>, c</u> | 1 11 | yatts | | ZIP CODE | | | 100 CIT | IZEN OF W | 1 YES 2 NO |
| the burial-transit permit. Pages 1, | FUNERAL | 5805 Queen | s Char | el Road | | | | 1 | 2078 | | | | | States |
| al-tra | 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN U. | S. ARMED | 13. | WAS DEC | ENDENT OF | F HISPAN | IC ORIGIN? (Specify Yes | | 14. RAOF | - American Indian |
| To the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the | BY F | 1 Never Married 2 S | | FORCES? 1 | | | 1 2 | if yes, spi | 2 3 NO | Specify | n, Puerto Rican, atc.) | | Speci. | , White, atc. |
| as th | | | | | | | | | X | | | | | White |
| esa | TED | (Specify only | EDENT'S EDUC highest grade | CATION completed) | 18 | (Give kind of life. Do NOT u | work done | during mo | ON st of working | 7 | 16b. KIND OF BUS | SINESS/INC | DUSTRY | |
| od for | 뿝 | Elementary/Secondary (0 | -12) | College (1-4 or 5 | | ivil S | | . C | Lowle | | 77.0 | 01. | | |
| detach once. | COMPLET | 17. FATHER'S NAME (First, MI | ddle, Last) | | | TATT 2 | CIVIC | e C. | | ED'C NAI | U.S. | | • | |
| 2 % | U U | William | Tow | msend | | | | | | Mary | | | | |
| 5 should notified | 00 | 19a, INFORMANT'S NAME (7) | rpe/Print) | | | 19b. MAILING | ADDRESS | (Street a | | | loute Number, City or Tow | | Code) | |
| e 5 s | 임 | Timothy V.A | . Dill | on_ | | 2933 | Garfi | eld. | Terr | ., N | N.W., Wash | . D.C | . 20 | 008 |
| funeral director, page 5 should be detached sixaminer must be notified at once. | | 20a. METHOD OF DISPOSITI | | oval from State | | ACE AND DATE | OF DISPOS | | | | | CATION - | | |
| director, I | | Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Commetter Comm | | | | | | | | | | | | |
| funeral di xaminer | | 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisc. ave., N.W., Wash. D.C. 2000 | | | | | | | | | | | ome | |
| he fur | | Ame | all | 5/1 | 1 | | 22 | 22 V | Visc. | ave | ., N.W., I | Wash. | D.C | . 20007 |
| or removal | | 23. PART I Enter the di | seases, or c | omplications the | t caused th | e deeth. Do | not enter | the mo- | de of dyir | ng, auch | as cardiec or respi | iratory an | reat, | Approximata |
| y filled i | | IMMEDIATE CAUSE (Fin | | | | , | | | | | | | | Interval Between Onset and Death |
| erely in | | Sequentially list conditions, If any, landing to immediate a. Caronary Arter Disease with Anging Due to (or as a consequence of): Caronary Arter Disease with Anging | | | | | | | | | | | | |
| signed by the attending physician and completely filled in by the Health and Mertal Hygiene prior to burial, cremation, or removal. ws any injury, or other traumatic event, the medical e | | | | DUE TO | (OR AS A'CO | INSEQUENCE O | IF): | | ۸. | | 1 0 | 11 | | |
| inding physician and co Hygiene prior to buria or other traumatic | O | Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| sician prior t | RTIFICATION | cause. Enter UNDERLYING | | | | | | | | | | İ | | |
| g phy iene p | FE | CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| al Hyg | ERI | reaulting in death) LAS | | l | | | | | | | | | | |
| ed by the att th and Menta any Injury, | LC | PART II. Other significan | nt conditions | contributing to | daath but r | not resulting | In the un | derlylno | ceuse d | lven in i | Part I. 24a. WAS AN | ALITOPSY | 245 | WERE AUTOPSY FINDINGS |
| d by | DICAL | | | | | | | , | | | PERFOR | MED? | 2.40 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Signe Health | | | | | | | | _ | | | 1 NES 2 | KNO | | OF DEATH? 1 ☐ YES 2 2 NO |
| been or. of | 7 | DID TOBACCO US | SE CONTR | RIBUTE TO CA | USE OF D | DEATH Y | ES 🗆 I | NO [| UNC | ERTAIN | R | | | TES ZAL NO |
| this certificate has been with the State Dept. of irked, or Item 23 sho | CIAN | 25. WAS CASE REFERRED TO EXAMINER? | | | | PLACE OF DEA | TH (Check | only one) | | | 7— 1 | | | |
| he Sta | YSICI | 1 TES 2 19410 | | HOSPITAL: | ER/Outpatie | nt 3 🗆 DOA | OTHER | | o 5 ☐ Res | ildenca | 8 Other (Specify) | | | |
| with th | H | 27. MANNER OF DEATH | | 28a. DATE OF (Month, D | | 28b. TIN | IE OF JURY | 28c. INJU | | | 28d. DEŞCRIBE HOW II | NJURY OC | CURED | |
| After this death with s marked | B | | Pending nvestigation | | | | М | | ES 2 🗌 | NO | | | | |
| after de | a | | Could not be | 28s. PLACE O building, | F INJURY — / etc. (Specify) | Al home, larm, | streel, fact | ory, office | 1 | | 281. LOCATION (Street a City or Town, State) | and Number | or Rural A | oute Number, |
| DIRECTOR: After hours after death item 28 is ma | L | an organism | | | | | | | | | | | | |
| 국 2 = | MPL | (Check only | | | | | | | | | to the cause(s) and man | | | |
| TO THE FUNERAL be filed within 72 h | 8 | | | t: On the basis of a | xemination an | d/or investigation | on, in my o | pinion, de | eath occure | d at the t | lime, date and place, an | d due to th | e cause(s) | and manner as stated. |
| POR V | 띪 | 296. SIGNATURE AND TITLE | | 2.0 | | | | | 29c. LICE | SE NUM | BER G 2 (/ | 29d. DAT | E SIGNED | (Month, Day, Year) |
| ₽ % ₹ | 5 | 30. NAME AND ADDRESS OF | PERSON WHO | | SE OF DEATH | ATEM OF A | Palast | | L | - 3/ | 934 | 8 | 1181 | 75 |
| | | Stephan | | ifoslio | MD | 7500 | Green | 200 | - Com | La D | ive Gree | 260 | 1 48 | 20774 |
| | | | | | R'S SIGNATU | BE | | 0 | | | 0466 | n sec | | - 7.0 |
| | | AUG 21 | 1995 | 32 REGISTRA | weless- | ardall | | | | | | | | |
| L | | | | 9 | | | | | | | | | | |



| 68760 | |
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| BOX | |
| P. 0. | |
| 90 | |
| RECORDS | |
| VITAL R | |
| OF | |
| DIVISION | |
| DIVIS | |
| _ | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DOWALD

31. DATE FILED (MODITI, DWG, 1607) 25 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | 1.0 | | | | | 95 | 2 | 1232 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------|-------------------------------------|-----------------------|-----------------------------------------------|----------------------------|---------------|--------------|----------------------|--------------------------------------------|
| FOR 1 - STATE | STATE OF MA | RYLAND | DEPARTM | IENT O | F HEALTH AND | MENTAL H | YGJENE | F. | | |
| REGISTRAR | | | | | OF DEATH | | EG. NO. | | | |
| 1. DECEOENT'S NAME (First, Middle, Last) | | _200 | | | | 2. DATE OF | DEATH DAY | Υ | YEAR | 3. TIME OF OEATH |
| ROY | | | AITES | | | AUG. | 23, | 19 | | 7:10 A M |
| 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. le | MO | UNDER 1 YE | AR IF UNDER 24 HRS. | 7. DATE OF E (Month, De | | | 8. BIRTNI Country | PLACE (State or Foreign |
| 127-26-2054 | 1X M 2 G F | 68 | YRS. | | | April | 8, 19 | | Tri | nidad |
| 90. FACILITY NAME (If not institution, give s | treet and number) | | 96 | | WN OR LOCATION OF D | EATH | | | NTY OF OE | |
| RESIDENCE OF DECEDENT | | | | носк | ville | | | Mon | tgom | ery |
| 10a. STATE 10b. COUNT | Y | - | 10c. CITY, TO | OWN OR L | DCATION | | | | | 10d. INSIDE CITY |
| Maryland Mont | gomery | | Rock | vill | е | | | | | LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | Ī | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| 1607 Yale Place | | | | | 20850 | | | Un: | ited | States |
| 11. MARITAL STATUS 1 Never Married 2 X Married | 12. WAS DECEDENT I | | | 13. WAS | DECENDENT OF NISPA a, specify Cuban, Mexic | NIC ORIGIN? (S | pecify Yes | or No— | 14. RACE Black | - American Indian, White, stc. |
| 3 Widowed 4 Divorced | IF YES, OIVE WAS | OR DATES | | | YES 2 X NO Speci | | | | Specifi | Dlask |
| 15. DECEDENT'S EDU | | 16a, DI | ECEDENT'S USL | IAL OCCUI | PATION | 16h KIN | D OF BUS | INESS /INC | HISTON | Black |
| (Specify only highest grade | College (1-4 or 5+) | (G | ive kind of work . Do NOT use re | done durin tired.) | g most of working | 100. 1411 | 0. 000 | | OSTAT | |
| | 4 | Acc | countan | t | | Acc | ount: | ing, | Self | employed |
| 17. FATHER'S NAME (First, Middle, Lest) | | | | | 18. MOTHER'S NA | | | | | |
| James | Thwa | aites | | | Gladys | | | G | eorge | 9 |
| 19a. INFORMANT'S NAME (Type/Print) | 011.5 | | | | eet and Number or Rural | Route Number, C | ilty or Town, | , State, Zip | Code) | |
| Elaine A. Thwait | es (Wife |) | Same a | s #1 | 0 | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 K Cremalion 3 Rem | oval from Stata | cemetery cre | AND OATE OF D | ntecel | | DATE | | | City or Tow | |
| 4 Donation 5 Other (Specify) | revere / | Chesa | peake | Crem | | 8-27 | | | lle, | MD |
| 11 0 | 0// | | | Rap | p Funeral | Servic | es, | P.A. | | |
| CUBAL 101 | The same | |)827 | 933 | Gist Ave | , Silve | r Sp: | ring | , MD | 20910 |
| 23. PART i. Enter the diseeses, or ahock, or heart fellure. | complications that of Liet only one cause | eused the de | eth. Do not o | enter the | mode of dyling, aud | ch as cardisc | or reapire | atory arr | eat, | Approximata Interval Between |
| IMMEDIATE CAUSE (Finel disease or condition | 1/1 T+ | - | 1- | | + | - 1 | | | n | Onset and Death |
| reaulting in death) | . Welast | alle a | telive | over | noma le | elle | 43 | and | live | |
| | DUE TO (O | R AS A CONSE | OUENCE OF) | | 0 +1 | , D. | V | | | |
| Sequentially list conditions, | OUE TO (O | R AS A CONSE | OUENCE OF | 4 | , the | cocor | 1 * | | | |
| If any, leading to immediate cause. Enter UNDERLYING | | 73. | , | (| | | | | | j |
| CAUSE (Disease or Injury that initieted events | DUE TO (O | R AS A CONSE | OUENCE OF): | | | | | | | + |
| resulting in death) LAST | d | | | | | | | | | |
| PART II. Other eignificant condition | e contributing to de | oth hut not | andeles to the | | | D. 24 | | | 1 | |
| The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | a continuating to de | TOTAL TOTAL | eeulung in ti | ie unden | lying cause given in | PBIT I. 248 | PERFORM | | | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| | | | | | | 1 [| YES 2 | NO | | COMPLETION DF CAUSE OF DEATH? |
| DID TOPACCO HEE CONTI | DIRLITE TO CALL | CE OF DEA | TIL VEC | | | | | | | 1 TES 2 X NO |
| DID TOBACCO USE CONTI | RIBUTE TO CAU | | E OF DEATH (C | | | иПП | | | | |
| EXAMINER? | HOSPITAL: | | 01 | HER: | | | 070 | | | |
| 27. MANNER OF DEATH | 28s. DATE OF IN | JURY | 28b. TIME OF | | Nome 5 Residence | 6 U Other (Spi | | JURY OCC | URED | |
| 1 Natural 5 Pending | (Month, Day, | Year) | INJURY | | WORK? YES 2 NO | | | | 701125 | |
| 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF I | NJURY — At ho | rme, farm, street | | | 261. LOCATION | N (Street an | d Number | or Rural Ro | oute Number, |
| 4 Nomicide determined | building, etc | - (Specify) | | | | City or Tou | wn, State) | | | |
| 290. CERTIFIER (Check only | CIAN: To the best of m | knowledge, de | eath occurred at | the Ilme. | dets and place, and due | to the cause(s) | and mann | or on state | nd. | |
| one) 2 MEDICAL EXAMINE | | | | | | | | | | and manner as stated. |

29c, LICENSE NUMBER
1) 00 95 7

Rd

Mill

Rockville

AM

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

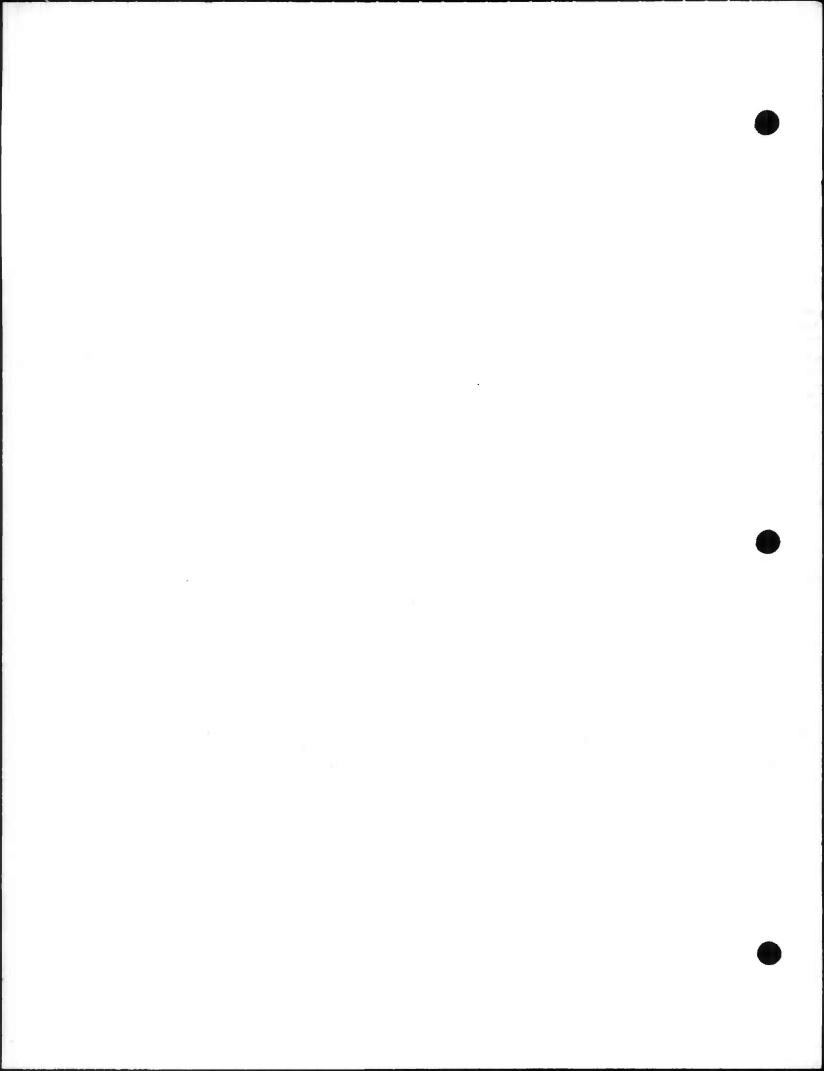
L B UC Y M D 809 UC LAS

32. REDISTRAR'S SIGNATURE

JULY D'UNCLUM RANGELL

29d. DATE SIGNED (Month, Day, Year)

8 - 23 - 95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

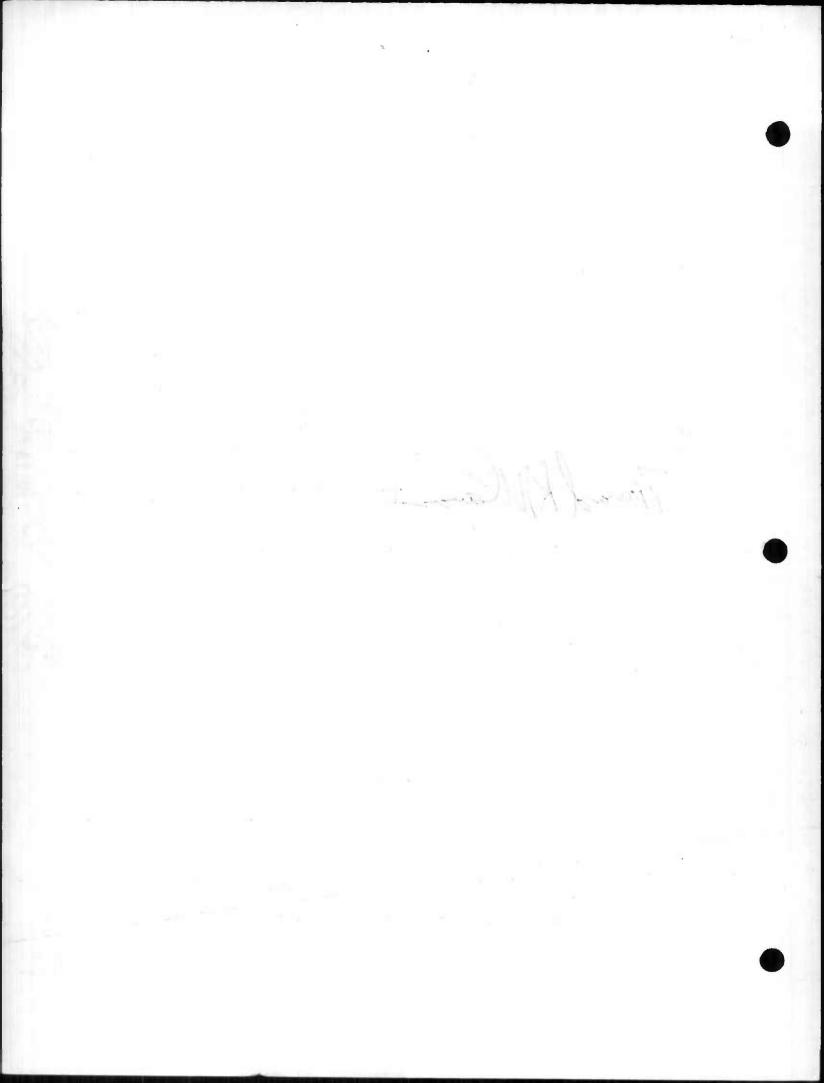
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | | |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------|-------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | STANLEY JOHN UJCIC | AUGUST 25 | 5 1995 | 7.30 A M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. ON ONTHIS DAYS HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | | LACE (State or Foreign |
| | 236-12-2501 1X 12 79 YAS. | 7-10-1916 | | Virginia |
| Œ | 90. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital Cumberland | ATH | c. COUNTY OF OE | ATH |
| 01; | Sacred Heart Hospital Cumberland | | Allega | any |
| DIRECTOR | 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY |
| | W. Va. Tucker XX Davis | | | LIMITS? |
| RAL | PO Box 132, Thomas Ave. 26260 | :1 | log. CITIZEN OF W | HAT COUNTRY? |
| FUNERAL | 20200 | | USA | |
| | 1 Never Merried 2 V Married FORCES? 1 YES 2 JNO If yes, specify Cuben, Mexican | n, Puarto Rican, etc.) | Black, | - American Indian, White, etc. |
| ВУ | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES A 1 YES 2 NO Specify | · | Specify | White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | 166. KIND OF BUSIN | ESS/INOUSTRY | |
| 3 | Elementary/Secondary (0-12) College (1-4 or 5+) Mile Do NOT use retired.) Mill 11 wright | Con | a + *** a + 4 | |
| ■ | 17. FATHER'S NAME (First, Middle, Lest) | ME (First, Middle, Maiden Sur | structi | On |
| BE C | Mike Ujcic Ursul | a Gerl | riarria) | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural F | Route Number, City or Town, S | State, Zip Code) | |
| | Freda Ujcic PO Box 132, Davis | W. Va. 2 | 6260 | |
| | 20e. METHOD OF DISPOSITION 1 1 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Complete, Cremetery of other place) Davis Cemetery 8 | 1 | TION — City or Tow | |
| ı | 4 Donation 5 Other (Specify) Davis Cemetery 8 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FAC | | vis, W. | Va. |
| | Hinkle Fundament | | , Inc. | |
| \dashv | 23 PART I Enter the diseases of approximation that avoid the day of the | Davis, | W.Va. | 26260 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such shock, or heart fellure. List only one cause on each line. | n aa cardlec or reepirat | ory erreat, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | Onset and Death |
| | resulting in death) a. CARDIOMYOPATHY DUE TO (OR AS A CONSCOUENCE OF): | | | a yrs |
| Z | Sequentially list conditions b. ISCHEMIC VASCULAR | DISEA | PE | 5YRS |
| E | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | 1 |
| F | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | - |
| CERTIFICATION | resulting in death) LAST | | | |
| | PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in I | | and I have | |
| CAL | CHRONIC LUNG DISEASE | Part i. 24a, WAS AN AU PERFORME | D? | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE |
| | CHILD DISENSE | 1 🗌 YES 2 🎉 | NO | OF DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IN UNCERTAIN | | | TES 2 NO |
| SA | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) | | | |
| YSIC | HOSPITAL: 1 Propellent 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence to | 8 Other (Specify) | | |
| H. | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? | 28d. DESCRIBE NOW INJU | PRY OCCURED | |
| B | 2 Accident Investigation Investigation Investigation | | | |
| COMPLETED | 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) | 281. LOCATION (Street and City or Town, State) | Number or Rural Ro | ute Number, |
| <u></u> | 29a. CERTIFIER (Check only CERTIFVING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the time. | | | |
| N N | (Check only Christ and Parsician: to the best of my knowledge, death occurred at the time, date and place, and due to one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time. | lime, data and place, and d | us to the cause(s) : | and manner as stated. |
| Ü | 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUM | | d. DATE SIGNED (| |
| 00 | taul J. dwener m) D23: | 774 | AUGUS: | |
| 2 | 30. NAME, AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | 11.1- | |
| | TAU Livengood M.D. 412 Seton Drive Cui | mberland | MD: | 21502 |
| | 31. DATE FILED (Month, Day, Year) SFP 06 1995 Jalia Martine SFP 06 1995 | | | |
| | DLA A D 1000 June | | | |

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| 300 | iding physician and completely filled in by the funeral director, page tygiene prior to burial, cremation, or removal. |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing and hours after death. Page 6 may b | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MAR | | ENT OF HEALTH AND ATE OF DEATH | | HYGIENE REG. NO. | | | | | |
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| J. | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF MONTH | | 3. TIME OF DEATH | | | | |
| | | | PTON, IV | | AUGU | ST 24 19 | 95 1745 F | | | | |
| | 4. SOCIAL SECURITY NUMBER 220-78-3175 9e. FACILITY NAME (If not institution, give | 1 💢 M 2 🗌 F | 21 YRS. MON | NDER 1 YEAR IF UNDER 24 HRS THS DAYS HOURS MIN | June June | 26, 1974 | Maryland Y OF DEATH | | | | |
| TOR | 16 NEPTUNE DRIVE JOPPA HARFORD | | | | | | | | | | |
| DIRECTOR | Maryland Harf | | 10c. CITY, TO JOE | opa | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | | |
| FUNERAL | 16 Neptune Drive | | | 101. ZIP CODE 21085 | | 10g. CITIZE | en of what country? | | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR | YES 2 XNO | 13. WAS DECENDENT OF HIS If yes, specify Cuber, Man 1 YES 2X NO Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specif | | | 4. RACE — American Indian, Black, White, atc. Specify: White | | | | |
| ETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | | 16a. DECEDENT'S USU. (Give kind of work of life. Do NOT use reti | lone during most of working | 16b. Kil | ND OF BUSINESS/INDU | STRY | | | | |
| COMPLET | 2.01101.0217.0010.0217 | 1 | Studen | t | | Coll | .ege | | | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | -2-110 | | 18. MOTHER'S | NAME (First, Midd | de, Malden Surname) | | | | | |
| BEO | Harry Elwood Upt | on III | | Mary | Elizabe | th Ihnat | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING ADD | RESS (Street and Number or Ru | ral Route Number, | | | | | | |
| | Harry Elwood Up | ton III | 16 Nept | tune Drive, J | oppa, M | laryland 2 | 21085 | | | | |
| | 23. PART i. Enter the diseased, or | RIVE | way # | | icComas urv Roa | ad, Abingdo | on, Maryland | | | | |
| | ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) BUE TO (OR AS A CONSEQUENCE OF): Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Deat | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | |
| 4 | PART II. Other aignificent condition | ne contributing to dec | eth but not resulting in th | e underlying ceuse given | in Part i. 24 | 4a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDIN AWAILABLE PRIOR TO | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CON | TRIBUTE TO CAUS | E OF DEATH YES | □ NO 😡 UNCERT | | ☐ YES 2 X NO | COMPLETION OF CAUS OF DEATH? 1 VES 2 NO | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (C | heck only one) HER: | | | | | | | |
| YS | 1 X YES 2 □ NO | 1 - Inpetient 2 - EF | I/Outpatient 3 DDA 4 | Nursing Home 5X Residen | | | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 8 / 24 / 9 | 10 286. TIME OF INJURY UNKNO | 28c. INJURY AT WORK? WILL 1 YES 2 XNO | SUBJ | ECT SHOT | SELF | | | | |
| 8 | 3 X Suicide 8 Could not be 4 Homicide determined | 28a. PLACE OF IN building, etc. | JURY — At home, form, atree (Specify) HOME | i, factory, offica | City or | ION (Street and Number of Town, State) IEPTUNE D | JOPPA | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHY | 0 0 / | | the time, date and place, and my opinion, death occured at | due to the cause | (a) and menner as state | | | | | |
| BE | BIOMATURE AND TITLE ON CHIEF | All | Aul | 29c. LICENSE O • C | | 29d. DATE | SIGNED (Morith, Day, Year) AUGUST 25,1 | | | | |
| 10 | Mario F. Golle | Jr. M.D. | | | altimo | ore, Mary | land 21201 | | | | |
| | AUG 2 9 1995 | 32. REGISTHAR'S | | | | | | | | | |



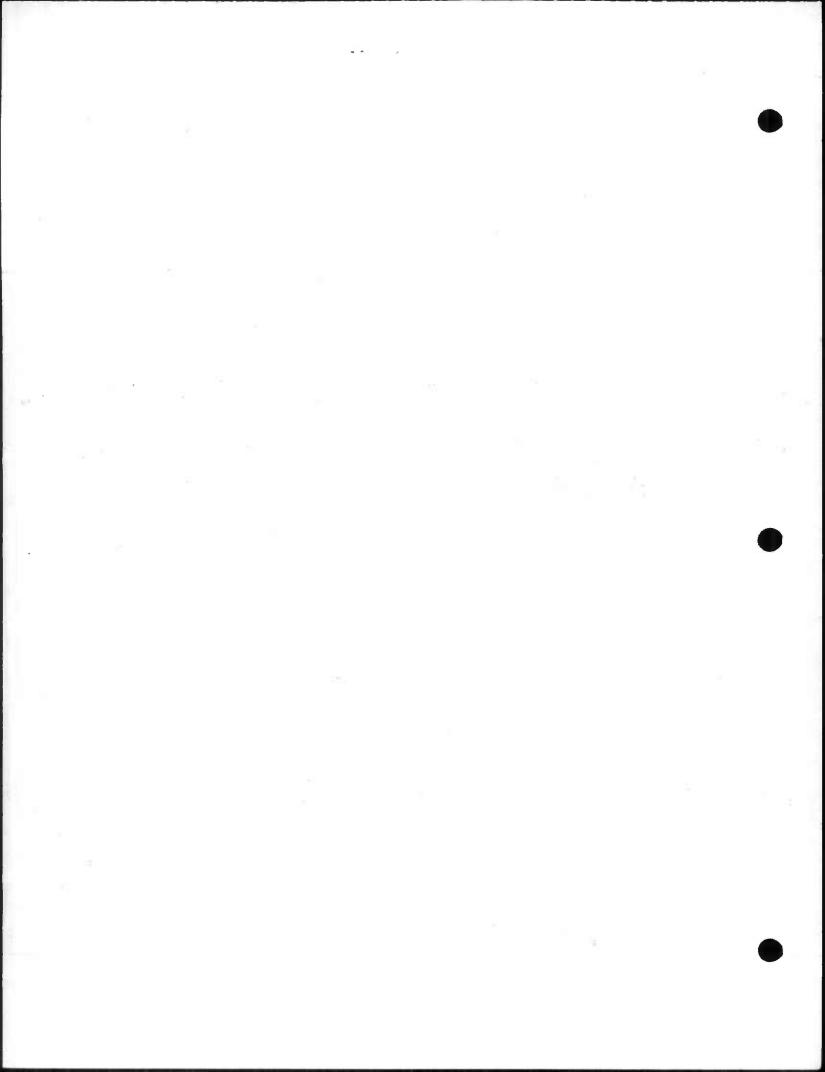
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| AL | AL | e filed within 72 hours after death with the State Dept. of I | RTANT: If item 28 is marked, or item 23 shows any injury, or oth |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN CHARLES WESLEY VOSHELL 2:45 95 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig DAYS HOURS 217-36-0397 1 X M 2 1 94 YRS 10/09/1900 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Caroline Nursing Home Denton, MD Caroline RESIDENCE OF DECEDEN 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Caroline Preston 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3259 Hunting Creek Road 21655 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian. Il yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married 1 TES 2 NO Specify: Specify: White B 3 😿 Widowed 4 🗌 Divorced ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) COMPLET Elementery/Secondary (0-12) College (1-4 or 5+) Dairy & Grain Farmer Dairy & Agriculture 8th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Levi Voshell Mattie Perry Voshell ш 0 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Joseph Voshell 22006 Gannon Dr., Preston, MD 21655 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1 Dt Buriel 2 Commetion 3 Removal Imm State 4 Donation 5 Other (Specify) Preston, Maryland der Cemetery | 25 Junior Order 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory screet, Approximate shock, or haart failure. List only one cause on each line. intarval Betwe DUE TO (OR AS A CONSEQUENCE OF): IMMEDIATE CAUSE (Finsi **Onact and Death** disesse or condition MONIC resulting in dasth) any CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL tai 1 TYES 2 THO OF DEATH? 1 YES 2 JANO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4 Nursing Nome 5 Residence 8 Other (Specify) 1 YES 2 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO ВУ Investigation 2 Accident 28e. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER
(Chack only)
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) **B** 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JUL 26 1995



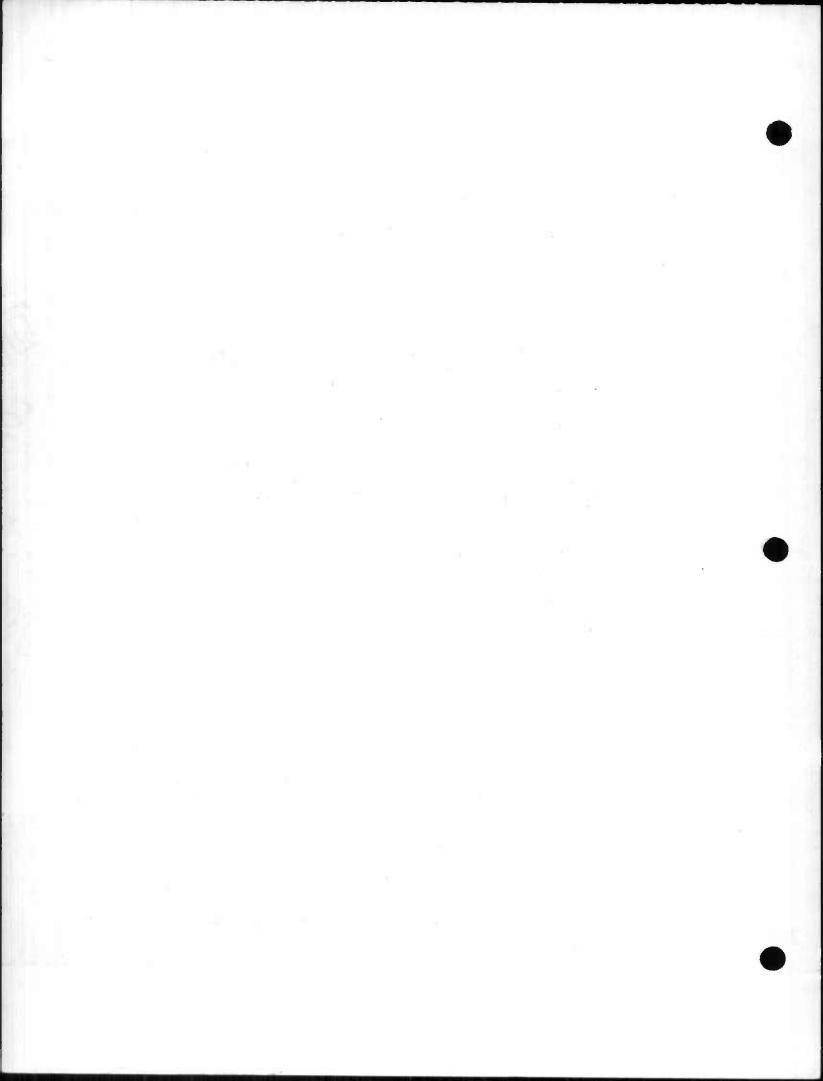
| THE HOSPITAL DR ATTENDING THE FUNERAL DIRECTOR: Afto be filed within 72 hours after dea MPORTANT: II flom 28 is m | THE MACESTAL IN ATTENDING PAYSICIAN. The law requires that the death certificate be executed with the four after the intending obsistion. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal. IMPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - FOR STATE OF MA | | MENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | OLIIII I | ALC OF DEATH | 2. DATE OF DEATH | | . TIME OF DEATN | | | |
| | ANTON | VON-HEITLINGER AUGUST 14, 1995 5. SEX 6. AGE (In yrs. lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPH | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 341-44-4509 9e. FACILITY NAME (If not institution, give street and number) | 42 YRS. M | F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN. b. CITY, TOWN OR LOCATION OF I | (Month, Day, Year) Feb. 12, 1953 | Country) | inois | | | |
| TOR | (IN WATER) SANDY LANDING RESIDENCE OF DECEDENT | | POTOMAC | VEATH 9 | MONTGO | | | | |
| DIRECTOR | none none | 10c. CITY, 1 | nington, D.C. | | 10d. INSIDE LIMITS? | | | | |
| FUNERAL | 3010 Wisconsin Ave., N.W. | | 10f. ZIP CODE 20016 | 1 | U.S.A | | | | |
| BY | | EVER IN U.S. ARMED YES 2 NO R OR DATES | 13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Maxie 1 YES 2 X NO Specify | cen, Puerto Ricen, etc.) | or No— 14. RACE — American Indian, Black, Whita, etc. Specify: White | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | 16e. DECEDENT'S US (Give kind of wor life. Do NOT use i | ESS/INDUSTRY | | | | | | |
| BE CON | 17. FATNER'S NAME (First, Middle, Last) Eugene V. von Heitlinger | | Dana | | | 130 | | | |
| 10 | Amy S. Bernstein | | DDRESS (Street and Number or Rura alifornia St., | | | 20009 | | | |
| | 20a. METNOD OF DISPOSITION 1 | 20b. PLACE AND DATE OF cametery, crematory or other Metropolit. | DISPOSITION (Name of r place) an Crematory A | OATE 20c. LOCAT | TION — City or Town | , State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF I DeVol Funera 2222 Wiscons | ACILITY 1 Home | | | | | |
| | 23. Part Enter the diseases, or complications that shock, or heert failure. Liet only one cause IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (| | enter the mode of dying, su | ich aa cardiac or reapirat | lory arreat, | Approximate Interval Between Onset and Daath | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DR AS A CONSEQUENCE OF): | | | | | | | |
| MEDICAL | PART II. Other aignificent conditions contributing to depend on the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of th | | | PERFORME 1 YES 2 | ED? | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\sum \) NO | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 28. PLACE OF DEATN | | | | | | | |
| PHYSICIAN: | 1 Inpetiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) IN WATET 27. MANNER OF DEATH 28. DATE OF INJURY 1 Netural 5 Pending Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Inves | | | | | | | | |
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| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of a MEDICAL EXAMINER: On the basis of ax | my knowledge, death occurred | at the time, date and plece, and d | ue to the cause(a) and manne | er as stated. | and manner as stated. | | | |
| TO BE C | 29b. SIGNATURE AND TIT LE OF CERTIFIE R | 66 | 29c. LICENSE N | | OGUST 1 | Month, Day, Year) | | | |
| F | 30, NAME AND ADDRESS OF PERSON WNO COMPLETED CAUS | | nni) | | | | | | |

132 REGISTRAR'S SIGNATURE

AUG 21 1995





Virginia

10g, CITIZEN OF WNAT COUNTRY?

Black

14. RACE — American Indian, Black, White, atc.

10d. INSIDE CITY YES 2 NO

Approximate

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

29 DATE SIGNED (Month, Day, Year)

COMPLETION OF CAUSE

Interval Between

Onset and Death

9c. COUNTY OF DEATH P.G.

U.S.A.

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STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) DATE OF DEATH Walker rence tugust 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8/7/1910 IF UNDER 24 HR IF UNDER 1 YEAR DAYS HOURS 1 - M 2 - F YRS. 223-38-3319 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR Prince Georges Hospital Cheverly RESIDENCE OF DECEDENT 10a STATE 10b, COUNTY 10c, CITY, TOWN OR LOCATION P.G. District Heights MD permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE the funeral director, page 5 should be detached for use as the burial-transit 1749 Addison RD. South 20747 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS
1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-3ALTIMORE, MARYLAND 21215-0020 1 TYES 2 TO NO B Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) unknown domestic private 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Roger Walker Lily Simms notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gilda Brown 1749 Addison Rd. S. District Hqts.MD. pe 20s. METHOD OF DISPOSITION
1 X Burlel 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) B/19/95 Landover, Md. 20b. PLACE AND DATE OF DISPOSITION (Name of Must Harmony "Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Hodges and Edwards Eilward nice 3910 Silver Hill RD. Suitland, MD. medical 23. PARTY. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, In by ahock, or heart failure. List only one cause on each line. ŏ filled IMMEDIATE CAUSE (Final the the cremation, disease or condition Leses pelentie cardid penal vas ental disease completely reaulting in death) other traumatic event, burial. CERTIFICATION 2 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a If any, leading to Immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 shows any injury, Me PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY and of PERFORMED? signed Health a 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REPERRED TO MEDICAL EXAMINER? or Item 26. PLACE OF DEATH (Check only one) certificate the State HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED with 1 Netural 1 YES 2 NO After the BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 60 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: hours after 28 4 Homicide determined 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE FIEG WITHIN 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

vary we MD

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Prior)

saughez.

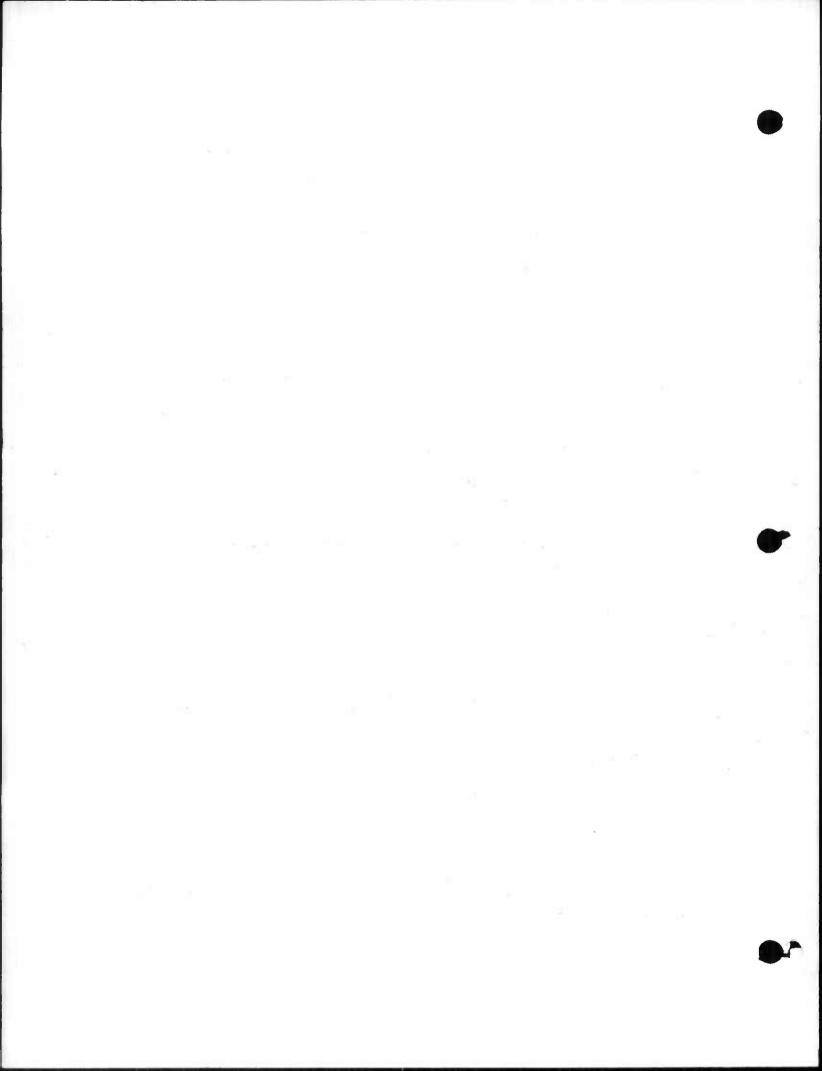
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

28c. LICENSE NUMBER

BE

2

29b. SJANATURE AND TITLE OF CERTJEJES



3. TIME OF DEATH

B. BIRTNPLACE (State or Foreign

9c. COUNTY OF DEATH

Montgomery

10g, CITIZEN OF WHAT COUNTRY?

Specify:

Landover, Md

Private

United States

14. RACE — American Indian, Black, White, etc.

Black

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE

1 YES 2 NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

intarval Between

Onset and Death

North Carolina

10d. INSIDE CITY LIMITS?

1 X YES 2 NO

REG. NO

2. DATE OF DEATH

MON

STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

31. DATE FILED (Month, Day,

AUG

15

23 1995

I. DECEDENT'S NAME (First, Middle, Last)

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6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 255-28-2274 1 X M 2 - F 81 YRS. Sept. 25, Pages 1, 2, 3 should Be. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Suburban Hospital Bethesda RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION District of Columbia Washington permit. FUNERAL 10e. STREET AND NUMBER be detached for use as the burial-transit 2508 - 4th Street, N.E. 20002 retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade complete) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Carpenter once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) John Henry Williams BE Mary Williams notified funeral director, page 5 should 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Tommie L. Surratt 2508 - 4th St., N.E.; Wash. Page 6 may be r D.C. 20002 pe 20s. METHOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must metery, crematory or other place) Harmony Memorial Park 8/26/95 examiner TURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 21190 4001 Benning Rd., N.E.; Wash., D.C. 20019 in by the f medical 23. PART I.\Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by shock, or haart failura. List only one couse on each line. ò IMMEDIATE CAUSE (Final ysician and completely fille prior to burial, cremation. the disease or condition_ DUE TO (OR ASIA CONSEQUENCE OF): resulting in death) traumatic event, aspiration preumonio CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate attending physician requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the atter Health and Mental Injury. PART II. Other aigniticant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY any periphers 1 YES 2 NO Shows peen 0 DID TOBACCO USE CONTRIBUTÉ TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. OR ATTENDING PHYSICIAN: The law 23 has 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item DIRECTOR: After this certificate I hours after death with the State Item 28 is marked, or Item HOSPITAL OTHER 1 | YES 2 | NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNEB OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide determined hours Hem 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL O TO THE FUNERAL DI DE filed within 72 ho IMPORTANT: If ite (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29h, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER ass up 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 9410 old Georgetown

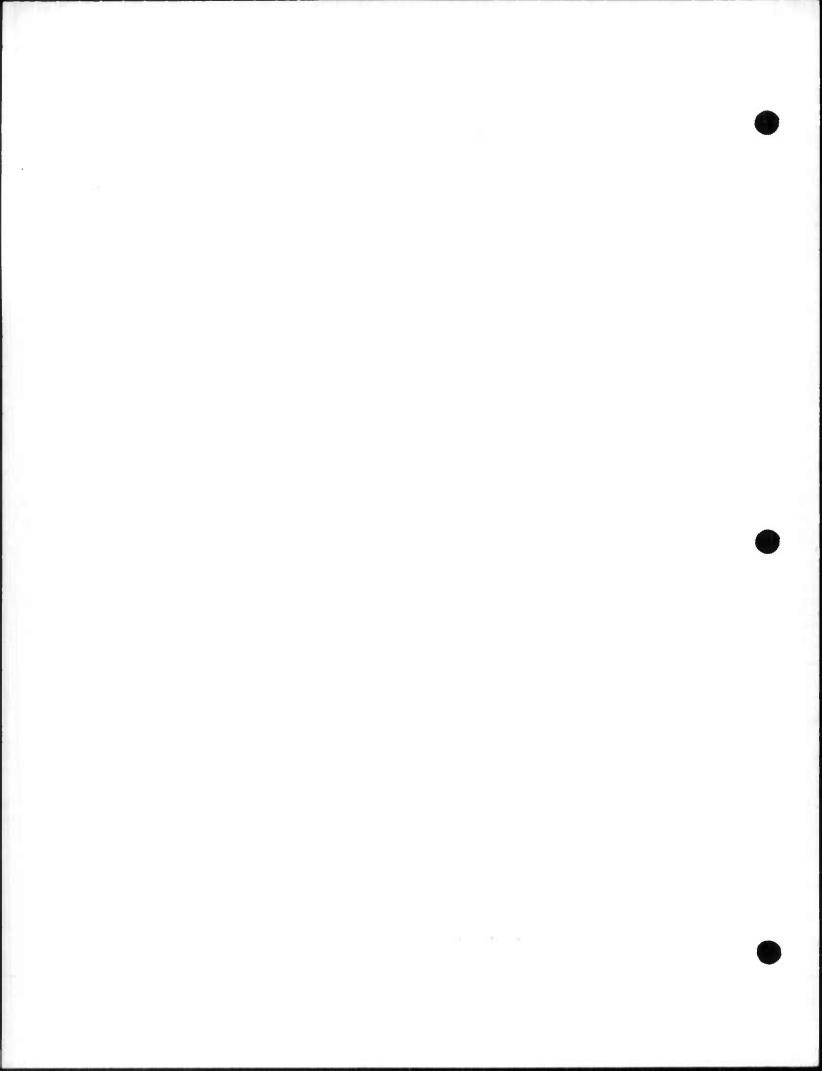
37 BEGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DNMH-16 Rev 1/89

1995



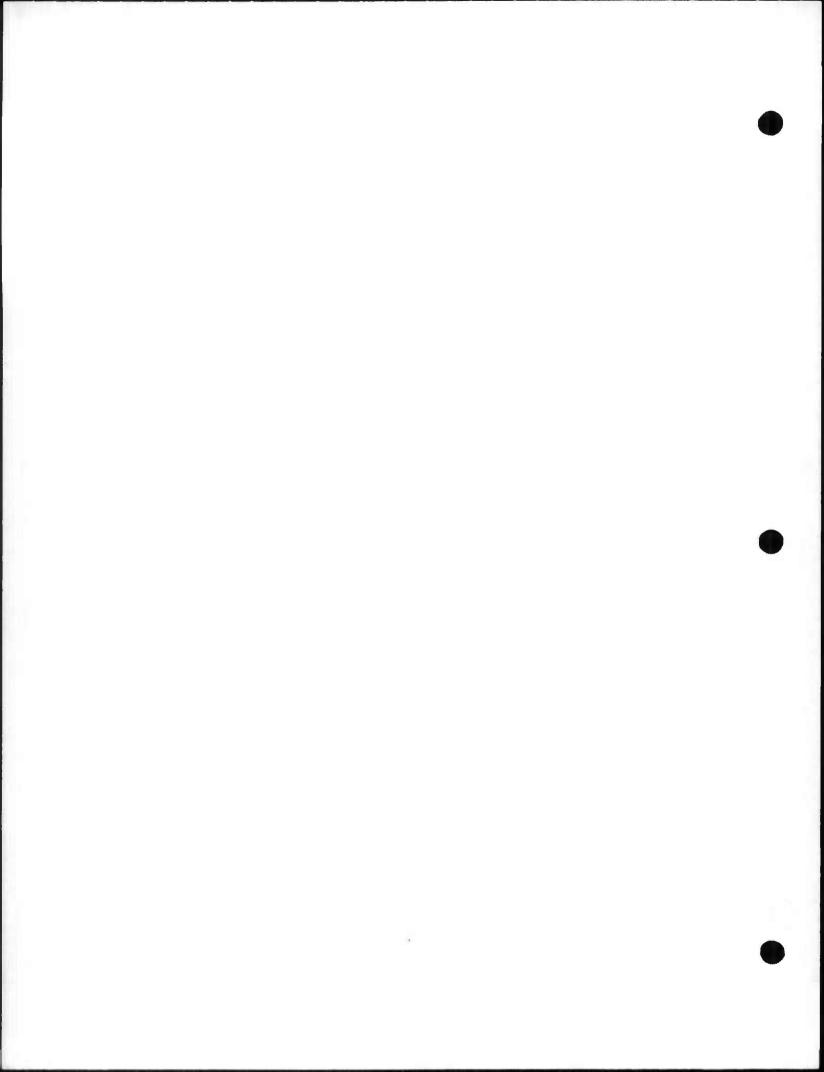
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) SUSIE MARZELL WILSON 4. SOCIAL SECURITY NUMBER 237-30-0398 1 | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------|
| 237-30-0398 1 M 2 KW 73 VRS. MONTHS DAYS HOURS MIN. MAY 26 19 | 5 YEAR | 5:00 P |
| 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN | 922 Wils | on, N.C. |
| N B TOTESEVITIE | Prince G | |
| 8 U 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | 1 | IOd. INSIDE CITY |
| Maryland Prince George's Forestville | | LIMITS? |
| HESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Forestville 10c. STREET AND NUMBER 10d. STREET AND NUMBER | 10g. CITIZEN OF WH | |
| 5 15 6437 Pennsylvania Ave. #102 20747 1 | JNITED ST | ATES |
| 6437 Pennsylvania Ave, #102 11. Marital status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Marr | Black, | - American Indian, White, atc. Black |
| 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) (Give kind of work done during most of working | NESS/INDUSTRY | |
| (Give kind of work done during most of working | | |
| HOUSEWIFE PRIVATE 17. FATHER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Meiden St. | | |
| PRIVATE 18. MOTNER'S NAME (First, Middle, Maiden St. P. DAVIS RICHARD E. DAVIS 18. MOTNER'S NAME (First, Middle, Maiden St. P. DAVIS 18. MOTNER'S NAME (First, Middle, Maiden St. P. DAVIS | urname) | |
| RICHARD E. DAVIS LESSIE ATKINSON | | |
| Y = S = O 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Burel Route Number, City or Town, | State, Zip Code) | |
| EVERETT D. WILSON 6437 Penn. Ave, "102 Forestville, | Md. 207 | |
| 20e. METNOD OF DISPOSITION XXBurial 2 Cremation 3 Removal from Stata 4 Donation 6 Other (Specify) WASHINGTON NATIONAL 8/23 Suit | ATION — City or Town | |
| 20s. METNOD OF DISPOSITION 20s. PLACE AND DATE 20c. LOCA 20s. METNOD OF DISPOSITION 20s. PLACE AND DATE 20c. LOCA 20s. METNOD OF DISPOSITION 20s. PLACE AND DATE 20c. LOCA 20s. METNOD OF DISPOSITION 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20c. LOCA 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE AND DATE 20s. PLACE A | land, Md | • |
| ALEXANDER S. POPE FUNERAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL METAL META | | |
| 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiec or reapira | OC 20020 | |
| 5 .= . e milock, or heart lenore. List only one cause on each line. | story arrest, | Approximate Interval Between |
| dieses or condition | | Onset and Death |
| disease or condition resulting in death) a. BRONCHOGENIC CARCINOMA Due to (or as a consequence of): | | 1 year |
| DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Infiliated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | |
| X a reposition of the cause. Enter UNDERLYING CAUSE (Disease or Injury) DUE TO (OR AS A CONSEQUENCE OF): C. | | |
| CAUSE (Disease or Injury that Initiated eventa reaulting in death) LAST | | |
| So and the standing in death) LAST that initiated events resulting in death) LAST d. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Red I. I are was as a | | |
| | | ERE AUTOPSY FINDINGS |
| | X. C | MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? |
| | | ☐ YES 2 ☐ NO |
| | | |
| DID TORACCO USE CONTRIBILITE TO CALISE OF DEATH VES XI NO II LINICEPTAIN II | | |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with nowns after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

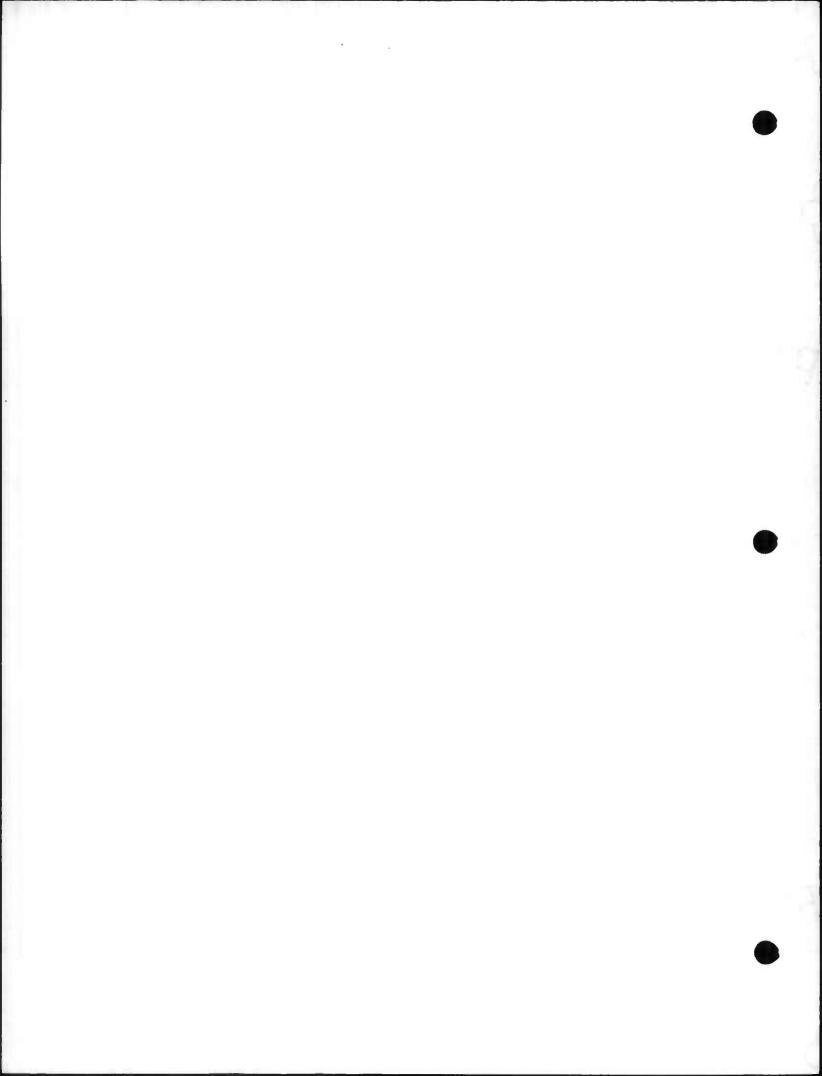
31. DATE FILED (Month, Day, Year)

AUG - 8 1995

| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAR | | | | | MENTA | L HYGIEN | E | | |
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| 0000 | 1. DECEDENT'S NAME (First, Middle, Lust) France | es Anna N | Wilson | | | | | | MONT | of DEATH DA | 199 | 5 YEAR | 3. TIME OF DEATH 12:05 P M |
| - 2 | 4. SOCIAL SECURITY NUMBER 220-36-9400 | 5. SEX 1 M 2 XF | 6. AGE (In yrs. Ia: | st birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | | /Monti | of BIRTH h, Day, Year) st 2,1 | 900 | Counti | IPLACE (State or Foreign y) Maryland |
| ron | 96. FACILITY NAME (If not institution, give s Asbury Methodist | | | | 9b. CITY | | ther: | ON OF DE | ATH | | 9c. COL | nty of o | EATH |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 100. COUNT Maryland Mon | tgomery | | 10e. CfT | Y, TOWN C | | on ther | sbur | g | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO |
| NERAL | 100. STREET AND NUMBER 301 Russell Avenue | | | | | tor | 208 | | | | | | vHAT COUNTRY? States |
| BY FUI | 11. MARITAL STATUS XX Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? t | IT EVER IN U.S. AF | | | if yes, sp | | n, Mexice | n, Puerto | f? (Specify Yes Rican, etc.) | or No— | t4, RACE Black Speci | E — American Indian, k, White, atc. //y: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | completed) College (t-4 or 5 | +) | ECEDENT'S live kind of a. Do NOT u | work done se retired.) | during mo | st of workir | | | . KIND OF BUS | SINESS/IN | DUSTRY | WIIICE |
| | 17. FATHER'S NAME (First, Middle, Linst) Harry Norma | 5+ | | ache: | r-Foi | reig | | HER'S NA | ME (First, I | Middle, Maiden | , | | ie. |
| TO BE | Harry Norman Wilson Martha Thomas Merrick 198. INFORMANT'S NAME (Type/Print) Matthe Thomas Merrick 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine B. Johnson 12005 Smoketree Road, Potomac, Maryland 20854 | | | | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burlet 2X Cremetton 3 Rem 4 Donation 5 Other (Specify) | ovat from Stats | 20b. PLACE cemetery, cri Montg | | | | | | | | CATION - | City or To | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | CERON | (Fo | N | EWN | | FUNE | CRAL | HOME | | | OM . MD |
| | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Complications the | it caused the deuse on each line | eeth. Do | ecio | the mo | de of dy | ing, suc | h as care | flac or respi | ratory ar | rest, | Approximate interval Between Onset and Death 5 YBARR |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | c | (OR AS A CONSE | | | | | | | | | | |
| MEDICAL C | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | | | |
| SICIAN: | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YO | HOSPITAL: | | | QTHE | 26. PL | | | eck only or | | | | |
| BY PHY | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28s. DATE OF INJURY (Month, Day, Year) 28s. DATE OF INJURY OCCURED NUMBER OF INJURY AT WORK? M 1 YES 2 NO 28s. DATE OF INJURY AT WORK? | | | | | | | | | Route Number, | | | |
| COMPLETED | 4 Homicide determined 29s. CERTIFIER (Check only | ed at the t | lme, dets | and place | | to the car | or Town, State) | iner se atr | nted. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFUE WE Compare the basis of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as atated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(s) and 29b. SIGNATURE AND TITLE OF CERTIFUE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month AUD 17 | | | | | | | | | | | | | |

JC- 207 Brodues

Jala Driver Cardall



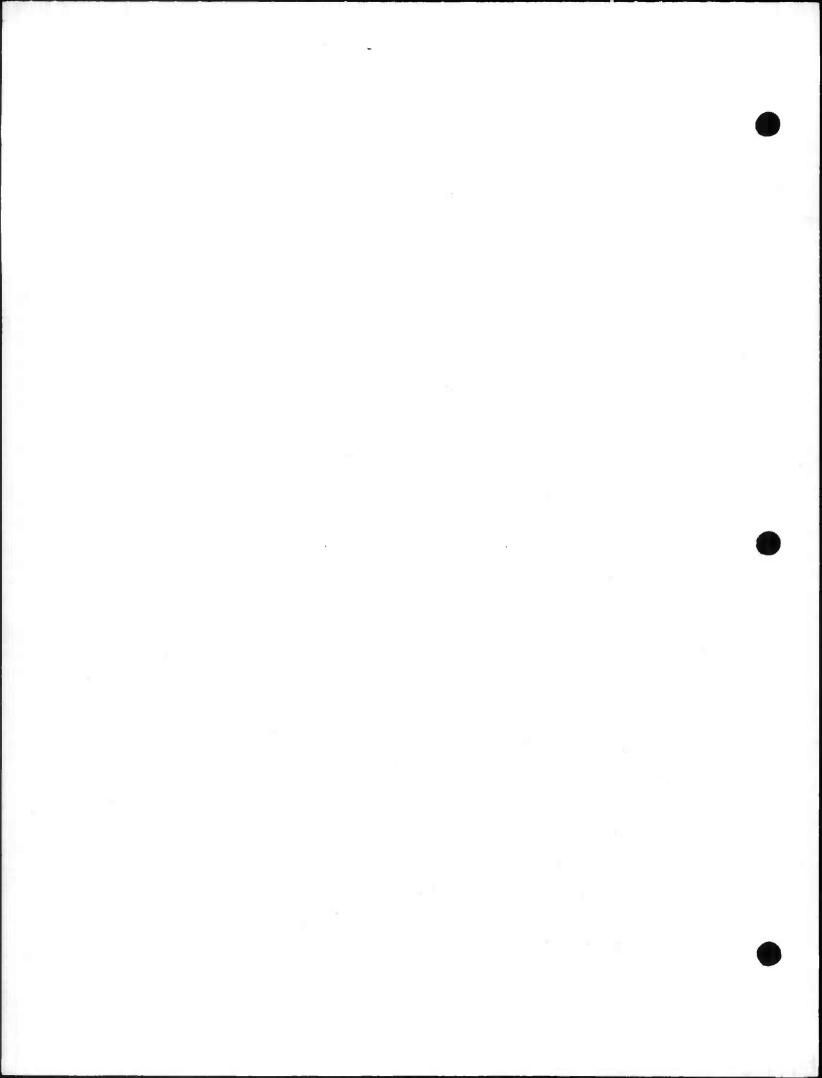
ALTIMORE, MARYLAND 21215-0020

| BALTIMORE, MARYLAND 21215-0020 | Ed hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | he medical examiner must be notified at once. |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. | IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. OECEOENT'S NAME (First, | Miridle Lest) | | | | | | | | 0.0475.00 | | | 1. | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------|-----------------------------------|-------------------------------------|-----------------|------------------------------------------------|----------------------|--------------------------------------------------|---------------------|------------------------------|-------------|------------------------|--------------------------------------------|
| | i. ocococier o remic ir not | , militari, Lilaty | | | | | 2. DATE OF OEATH MONTH DAY YEAR A U.G. 12 1995 | | | . TIME OF DEATH | | | | |
| | 4. SOCIAL SECURITY NUMB | OLIV | J | | | | AUG. | | 2 1 | | 2:00 A M | | | |
| | 4. SOCIAL SECURITY NUMBER 2 1 9 − 0 1 − 8 0 5 0 1 □ M 2 元 F | | | - trade: to a trade | 2000 | | | HOURS | NDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) | | BIRTH Day, Year) | | 8. BIRTHPI Country) | LACE (State or Foreign |
| ļ | 9e. FACILITY NAME (If not in | 8. | 7 YRS. | 04/18 | | | | | 18/0 | | | land | | |
| œ | | | | | 96. CITY, TOWN OR LOCATION OF DEATH | | | | | 9c. COUNTY OF OEATH | | | | |
| DIRECTOR | Wesleyan | | th Care | Cente | er | r Denton Caroli | | | | | colin | e | | |
| E I | 10e. STATE | 10b. COUNTY | | | 10c. C/1 | Y, TOWN | OR LOCAT | TION | | | | | t | ed. INSIDE CITY |
| ă | Maryland | Ca | roline | | | | | Pr | est | on | | | | LIMITS? |
| A | 10e. STREET AND NUMBER | | | | | | 101 | I. ZIP COD | E | | | 10g. CIT | | AT COUNTRY? |
| FUNERAL | 21860 M | aryla: | nd Aven | ue | | | | 2.1 | 655 | | | Uni | ted | States |
| 5 | 11. MARITAL STATUS | | 12. WAS OECEOEN | T EVER IN U.S. A | ARMEO | 13. | WAS DEC | ENOENT (| F HISPAN | IC ORIGIN? | Specify Yes | | 14. RACE - | - American Indian |
| ВУ Р | 1 Never Married 2 3 XWidowed 4 Divo | | IF YES, GIVE W | YES 2 3 | ΨNO | | | ecify Cube | | n, Puerto Ric | en, etc.) | | Black, Specify: | White, etc. |
| | | | | | | | | | | | | | | White |
| COMPLETED | | EOENT'S EOUG y highest grade | | | Give kind of | work done | during mo | DN ost of working | ng | 16b. K | NO OF BUS | INESS/IN | OUSTRY | |
| ۳ | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 + | •) | Home | | | | | Ov | n Ho | ome | | |
| MP | 8th | | | | поше | mak | e r | | | | | | | |
| | 17, FATHER'S NAME (First, M | | Thomas : | Deneau | | | | | | ME (First, Mid | | Surname) | | |
| H | 19a. INFORMANT'S NAME (7 | | THOMAS . | | | | | | | Perr | | | | |
| 2 | Forrest D | | | | | | | | | Route Number, | | | | 1655 |
| | 20a. METHOD OF OISPOSITE | | | | | | _ | | , ku | | - | | | |
| | 1 Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other | n 3 🗆 Rame | oval from State | cemetery, c | E ANODATE | ther place) | 1 | | | DATE | | | City or Town | ryland |
| | 21. SIGNATURE OF FUNERA | | ENSEE | Jun | ior (| | | emet | | | 1110 | 3001 | 1, 110 | ryrand |
| | D 100 . 1 | 01 | 100 | 1 | | | | | | | s-Es | kow | Fune | ral Home |
| | Mulle | ser + | - Esko | w | | P | 0 B | ox 4 | 13, | Fede | rals | burg | y, MD | 21632 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one ceuse on each line. Approximate interval Between | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final Onset and Desth | | | | | | | | | | | | | |
| | resulting in death) | → , | adv | ava | ed | de | me | int | 10 | | | | | |
| | disease or condition and varied dementa DUE TO (OR AS A CONSEQUENCE OF): Alrheimen's different years | | | | | | | | | | | | | |
| S O | Sequentielly list conditione, | | | | | | | | | | | | | |
| F | If any, leading to immediates. Enter UNDERLYI | | 002 10 | (OH AS A COHS | EOUENCE U | rj: | | | | | | | | 1 |
| CERTIFICATION | CAUSE (Disease or injuthat initiated eventa | ny \$ ' | OUE TO | (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| E | resulting in deeth) LAS | Т | 4 | | | | | | | | | | | ! |
| | | | | | | | | | | | | | | |
| MEDICAL | PART II. Other significe | nt condition | e contributing to | deeth but not | reculting | In the u | nderlyin | g cause | given in | Part I. 2 | la. WAS AN PERFOR | | | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO |
| ă | CH | | | | | | | | | 1 | YES 2 | KNO | | OMPLETION OF CAUSE OF DEATH? |
| M | | | | | | | | | | _ | | | 1 | ☐ YES 2 ☐ NO |
| | | | | | | | | | | | | | | |
| ᅙ | 25. WAS CASE REFERRED TO EXAMINER? | O MEOICAL | HOSPITAL: | | - | OTHE | | LACE OF O | EATH (Che | ock only one) | | | | |
| Z Z | 1 TYES 2 NO | | 1 Inpatient 2 | ER/Outpatient | 3 🗆 DDA | | | se 5 □ Re | aldence | 8 🗆 Other (S | Specify) | | | |
| PHYSICIAN | 27. MANNER OF OEATH | Pending | 28e. OATE OF (Month, D | | 28b. TIN | IE OF | 28c. INJ WO | URY AT | | 28d. OESCF | IBE HOW II | NJURY OC | CUREO | |
| B | 2 Accident | М | | YES 2 | NO | | | | | | | | | |
| ا ۵ | | Could not be | 28a. PLACE O building, | F INJURY — At I atc. (Specify) | home, ferm, | street, fac | tory, offic | • | | | ON (Street a Town, State) | nd Numbe | r or Rural Rou | ite Number, |
| | | | | | | | | | | | | | | |
| ᆲᆘ | | | CIAN: To the best of | | | | | | | | | | | |
| COMPLETE | one) 2 MEOI | CAL EXAMINE | R: On the basis of a | ramination and/o | r Investigation | on, in my | opinion, d | leath occur | red at the | time, data en | d place, en | d due to ti | ha cause(a) a | and manner as stated. |
| BEO | 296, SIGNATURE AND TITUE | OF CERTIFIER | 0 | | 100 | | | 29c. LICI | ENSE NUN | BER | | 29d. DAT | E SIGNEO (A | Aonth, Day, Year) |
| | - y ^S | 1 | | · u | 10 | | | D: | 337 | 68 | | DA | ug 2 | 1,1995 |
| 임 | 36. NAME ANO ADDRES | | | | | | 93 | | | | | | 0 | |
| | Dr. James E. | | n P.O. | Box 660 | Der | iton, | , MD | 216 | 29 | | | | | |
| | 31. DATE FILED (Month, Day, | Year) | 32, RECOSTRA | RIS SIGNATURE | Randal | | | | | | | | | |
| | AUG | 2 2 199 | 151 /200 | thin when | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-motirs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|-------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------|----------------------------------------------------|-------------------------------------|-----------------------|--------------------------------------------------|--|--|--|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Jay | Frank | Weilan | d | July | 20, 19 | 95 8:00 a M | | | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. | 7 DATE OF BIRTH | T. | BIRTNPLACE (State or Formion | | | | |
| | 222-68-9825 | 1 □X M 2 □ F 37 | YRS. | MONTHS DAYS HOURS MIN. | Mar. 1, | 1958 | Easton, MD. | | | | |
| ~ | 9a. FACILITY NAME (If not institution, give str | | | 9b. CITY, TOWN OR LOCATION OF | DEATH | | Y OF DEATN | | | | |
| 0 | 205 Greenridg | e Road | | Federalsbur | g | C | aroline | | | | |
| S | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 18c CIT | Y, TOWN OR LOCATION | | | I | | | | |
| DIRECTOR | MD. Carol | ine | | Federals | nura | | 10d. INSIDE CITY LIMITS? | | | | |
| AL A | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | , u. g | 10e CITIZE | 1 TYES 2 NO | | | | |
| ER. | 205 Greenrid | ge Road | | 21632 | | | SA | | | | |
| FUNERAL | 11, MARITAL STATUS | 12 WAS DECEDENT EVER | N U.S. ARMED | 13. WAS DECENDENT OF HISP | ANIC ORIGIN? (Specify | Yas or No 14 | I. RACE — American Indian, | | | | |
| ВУБ | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | 2 X NO | It yes, specify Cuben, Maxi- 1 YES 2 XNO Spec | | | Black, White, etc. | | | | |
| | | | | | | | Specify: White | | | | |
| COMPLETED | 15. DECEDENT'S EDUCI (Specify only highest grade of | ompleted) | 18a. DECEDENT'S (Give kind of v life. Do NOT us | USUAL OCCUPATION work done during most of working | 16b. KIND OF | BUSINESS/INDUS | STRY | | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | 10 | | | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | 0 | Searo | od Dealer | IAME (First, Middle, Mai | es/Seat | T000 | | | | |
| | James Frank | k Weiland | 1 | | | | | | | | |
| BE C | 19a. INFORMANT'S NAME (Type/Print) | · werrance | | ADDRESS (Street and Number or Rura | OSE Arca | Town State Zin C | orial 0.4.6.0.0 | | | | |
| 5 | J. Frank Weila | and | | Vest Central | | | | | | | |
| | 20a. METNOD OF DISPOSITION 1 [V] Buriel 2 Cremetion 3 Remov | ml from State 20t | . PLACE AND DATE O | F DISPOSITION (Name of | | LOCATION - CIT | | | | | |
| | 4 Donation 5 Other (Specify) | an from state can | HIT CY | est Cemetery | 7/22/95 | Feder | ralsburgMD. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | | 22. NAME AND ADDRESS OF F | ACILITY | | | | | | |
| | 1000 | | | Williamso | n Funera | 1] Home | 9 | | | | |
| | 23. PART I. Enter the disesses, or co | mplications that csuse | d the desth. Do n | Federalsh ot enter the mode of dying, au | ch as cerdiac or re | epiratory arres | t, Approximate | | | | |
| | ahock, or heart fallure. Li IMMEDIATE CAUSE (Finel | at only one cause on e | ach line. | | | | Interval Between Onset and Death | | | | |
| | disease or condition resulting in death) | HANGI | ANGING | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| S | Sequentially list conditions, b. | DUICID | E | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS / | CONSEQUENCE OF |); | | | | | | | |
| E | resulting in death) LAST | | | , | | | | | | | |
| | DART II On a shall be a second | | | | | | | | | | |
| CAL | PART II. Other algnificant conditions | contributing to deeth b | ut not reculting in | n the underlying ceuse given is | | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | |
| MEDIC | DEPRESSIO | | | | 1 🗆 YES | 2 NO | COMPLETION OF CAUSE OF DEATH? | | | | |
| | CHRONIC P | ATIN | | | | | 1 TYES 2 NO | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | |
| SCI | EXAMINER? | HOSPITAL: | | 26. PLACE OF DEATH (C | | | | | | | |
| Ě | 27. MANNER OF OEATH | 28a. DATE OF INJURY | 28b. TIME | | 8 Other (Specify) 28d. DE\$CRIBE NO | W IN ILITY OCCUM | 200 | | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJU | M 1 YES 2 NO | 200. DESCRIBE NO | WINDOWY OCCUP | 4ED | | | | |
| 2 Accident Investigation 1 YES 2 NO | | | | | | | | | | | |
| TED | 4 Homicide determined | building, etc. (Spec | ory) | | City or Town, Sta | ite) | | | | | |
| COMPLET | 29a. CERTIFIER (Check only | AN: To the best of my know | ledge, death occurre | d at the time, date and place, and du | a to the cause(s) and | | | | | | |
| NO. | | | | , in my opinion, death occured at the | | | euse(s) and manner as statut. | | | | |
| ECC | 295 SIGNATUPE AND TITLE OF CERTIFIER | 140 | | 29c, LICENSE NU | | 29d DATE SI | 1 1 | | | | |
| 00 | C.E. Jensen | (MY) | FOUTH | ME DI | 464 | D 17 | 197195 | | | | |
| 2 | 30. NAME AND A DOWESS OF PERSON WHO | COMPLETEO CAUSE OF OE | ATN (ITEM 27) (7/20. | Print) | WAR 41 | 000 | 0 1 0 | | | | |
| | L.E. JENSE | WMD. | 1.0.1BC | X 690, DE | NON | MO | 21624 | | | | |
| | JUL 31 1995 | A REGISTRAR'S LIGHT | Wirdell | | | | | | | | |
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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | RTMENT OF I | | MENTAL HYG | | | |
|----------------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------|------------------------------------------------|-------------------------------------------------------------|------------------------------------------------|----------------------------|--------------------------------------------------------------------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) By: | ron Delbert | t Walter | | | 2. DATE OF DEAT MONTH AUG 20, | TH DAY | 3. TIME OF OEATH | |
| 29 | | 578-38-4598 | 5. SEX 6. AGE (| (In yrs. lest birthday) | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTI (Month, Day, Vo Sept 10 | H 8 | BIRTHPLACE (State or Foreign Country) [aryland] | |
| 2, 3 should | стов | 9a. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH | | | | | | | | |
| physician. burial-transit permit. Pages 1, | DIREC | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY Maryland Anne | Arundel | | ry, town or Loca othian | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | |
| n. ansit perm | FUNERAL | #1 Boones Drive | | | 10 | 7. ZIP CODE 20711 | | 234 | n of what country? | |
| the th | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 X YES | 2 NO | If yes, sp | CENDENT OF HISPAN Decity Cuban, Maxica S 2 NO Specify | n, Puerto Rican, etc | 2.) | Black, White, etc. Specify: | |
| ital or attend for use as | LETED | | TION Impleted) College (1-4 or 5+) | (Give kind of life. Do NOT u | | ON ost of working | | F BUSINESS/INDUS | | |
| S 6 5 | COMPL | 12 17. FATHER'S NAME (First, Middle, Last) Sidney (| G. Walters | Refrige | ration | | Peo ME (First, Middle, Mi E. Atkin | alden Surname) | rug Store-30 Yr | |
| retained to 5 should notified | TO BE | 19a. INFORMANT'S NAME (Type/Print) Doris A. Walters | 3. Walters | | | and Number or Rural I | Route Number, City o | r Town, State, Zip Co | | |
| 2 2 | | 20e. METHOD OF DISPOSITION 1 | cem | PLACE AND DATE | of oisposition (N. Other place) Veterans | Cemeter | 4, 10995 20 Y C | LOCATION — CIR heltenha | y or Town, State m, Maryland | |
| or death. Pag he funeral di ral. | | 21. SIGNATURE OF FUNERAL SURVICE LICEN | Have | 1 | | | | | come, Inc 6633 inton, Md 20735 | |
| fled within 24 hours after death. Page 6 m completely filled in by the funeral director, ial, cremation, or removal. | | 23. PART i. Enter the diseases, or conshock, or heart feilure. Lie iMMEDIATE CAUSE (Final disease or condition resulting in death) | Pm | i the death. Do ach line. | ria Pri: | | | | Approximate Interval Between Onset and Death | |
| h certificate be exect anding physician and Hygiene prior to bur or other traumation | RTIFICATION | Sequentially list conditions, if sny, leading to immediste cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | CONSEQUENCE O | F): | nong 6 | The Por | ngue | 10 mg | |
| th the by the and Me | EDICAL CE | PART II. Other significant conditions | contributing to death be | ut not resulting | in the underlyin | g cause given in | PE | S AN AUTOPSY REFORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| has b Dept. | AN: M | DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL | | | ES NO C | UNCERTAIN | 10 | | 1 TES 2 NO | |
| ician: certifica the Str | PHYSICI | | HOSPITAL: Inputient 2 ER/Outp | 26b, TIN | E OF 28c. INJ | ne 5 🗆 Residence | | | RED | |
| ATTENDING PHYS CTOR: After this cafter death with 128 is marked. | D BY | 2 Accident Investigation | | | | | | | | |
| TAL DR AL DIRE 72 hour | COMPLETE | | AN: To the best of my knowl | | | | to the cause(a) and | I manner as stated. | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | O BE CO | 29b. SIGNATURE AND TITLE OF CENTIFIER | 3m | m | | 29c. LICENSE NUM D38563 | IBER | 29d. DATE S | IGNED (Month, Day, Year) | |
| | T | 30. NAME AND ADORESS OF PERSON WHO O | .34 Owensvil | le Road, | West R | iver, Mar | yland | 7 | 5 | |
| | | 31. DATE FILED (Month, Day, Year) 1995 | 32. REGISTRARIE SIGNA | ATURE Ravdall | | | | | | |

by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 Page 6 may be retained

as the burial-transit permit. Pages 1, 2, 3 should

asn

page 5 should be detached for

director,

YOU X C 0 PECOPOS DIVISION OF VITAL

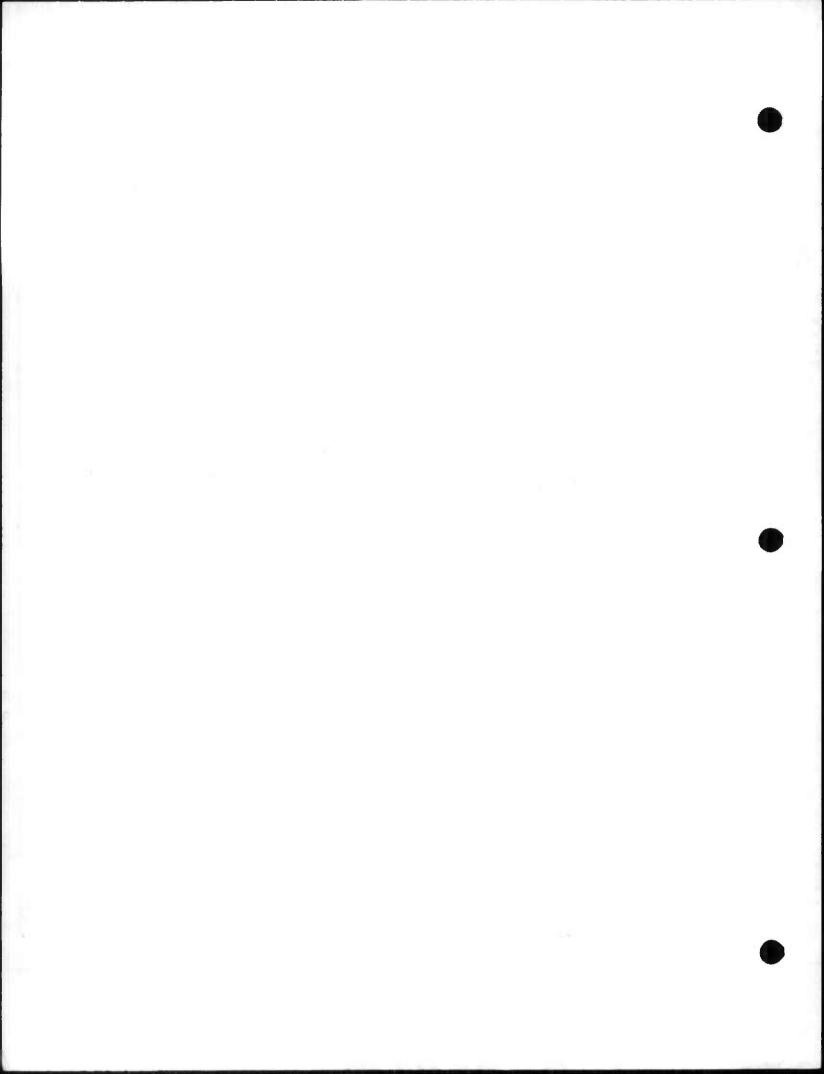
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| | HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de- | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu | within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH TRACIE KEN WILLETT 23 1993 AUG 840 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Forming 1 M 2 K F 33 539-66-1427 1962 August 6, Washington 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1129 Keswick Place Frederick Frederick RESIDENCE OF DECEDEN 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1129 Keswick Place 21703 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi Elementary/Secondary (0-12) College (1-4 or 5+) 12 Personnel Office Grocery notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Wayne D. Willett Lynn R. Byrum 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Thomas 1129 Keswick Place, Frederick, MD 21703 90 20a. METHOD OF DISPOSITION
t ☐ Burlel 2 ☑ Cremation 3 ☐ Ramoval from State
4 ☐ Donation 6 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Hagerstown Crematory 8/28 Hagerstown, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. mend 1621 Opossumtown Pike, Frederick, MD 21702 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. Interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death the disease or condition STRANGULATION BY LIGATURE MINUTES resulting in death) shows any Injury, or other traumatic event, crem DUE TO (OR AS A CONSEQUENCE OF burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to desth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO 1 YES 2 NO item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 NYES 2 NO 4 - Nursing Home 5 M Residence 6 - Other (Specify) marked, or the 27. MANNER OF DEATH 28a. OATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investige HANGING AUG 23 1995 BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building. etc. (Specify) 281. LOCATION (Street and Number or Byrat Boute Nymberk PL City or Town, State) 1129 RESWICK PL 3 Suicide 60 COMPLETED 6 Could not be after HOME 4 Homicide determined Item 28 FREDERICK Md 21702 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as steted. IMPORTANT: If 2 MEDICAL EXAMINER: On the basis stigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner se stated. D09867 29d. DATE SIGNED (Month, Day, Year) BE 표보를 ► Aug 23 1795 223 9 7 PAST EREDERICE

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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR | TMENT OF | HEALTH AND | | YGIENE | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | e Fie | 2(8 | 2. DATE OF D | DAY | S. TIME OF DEATH |
| pin | | 000 11 0000 | □ M 2 🕱 F 7 : | yrs. last birthday) YRS. | # UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | 9,1923 | BIRTHPLACE (State or Foreign Country) Maryland |
| 1, 2, 3 should | CTOR | Montgomery Gene | | ta1 | | ney | EATH | | ntgomery |
| Pages | DIRE | Maryland Howa: | rd | | y, town on Loca oodbine | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 10 NO |
| in. ransit permit, | VERAL | 2830 Florence R | | | 10 | 21797 | 7 | | S.A. |
| 215-0020 attending physician. use as the burial-transit | BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | If yes, s | CENDENT OF HISPA pecify Cuban, Mexico 8 2 NO Specific | en, Puerto Ricen, | | RACE — American Indian, Bleck, White, atc. Specify: White |
| 21 or u | LETED | | oleted) | (Give kind of v | USUAL OCCUPATION of doring more retired.) | osl of working | | | eographic |
| ALTIMORE, MARYLAND 2 death. Page 6 may be retained by the hospital funeral director, page 5 should be detached to examiliner must be notified at once | COMPL | 12 17. FATHER'S NAME (First, Middle, Last) | son | Tillanc | Ida Mi | 18. MOTHER'S NA | | Socie Maiden Surname) | |
| MARYL retained by 5 should be | | 19a. INFORMANT'S NAME (Type/Print) | | 19b, MAILINO | ADDRESS (Street | | | C. Kirb | |
| ay be ret | | Regina W. Rigle | | 879 | Long | Corner | Road,1 | Mount Ai | ry,Maryland |
| MOR age 6 ma director, p | | 1X Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | from State PC | | Springs | | | 30 Mt. A | iry,Maryland |
| ee u 2 2 | | 21. SIGNATURE OF FUNERAL SERVICE LICENS COlin L W | Tolesu at | h | 01in | | eswort | | Funeral Home s, Maryland |
| y filled in the stion, or re- | | 23. PART I. Enter the diseases, or com- shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) | olications that caused only one cause on each | the death. Do not line. | not enter the mo | ode of dying, suc | th as cardiac o | to aut | Approximate Interval Between Onset and Death |
| P 0 0 1 0 | | | DUE TO (OR AS A (| CONSEQUENCE OF | F): | | P | soas | |
| Si cian | SATIC | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A C | CONSEQUENCE OF | F): | | | | |
| S, P.O. Bodeath certificate eattending physicianal Hygiene print. urv. or other t | CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | DUE TO (OR AS A C | CONSEQUENCE OF | ፣): | | | | |
| that the ed by the th and w | JCAL | PART II. Other algorificent conditions co | acido | t not resulting i | | g ceuse given in | (| WAS AN AUTOPSY PERFORMED? YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| REC requires been sign t, of Heal | Σ | DID TOBACCO USE CONTRIBI | | DEATH VE | SUNOF | UNCERTAI | | | 1 TES 2 NO |
| VITAL AN: The law inficate has b State Dept. | SICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 8. PLACE OF DEAT | H (Check only one) OTHER: | ne 5 Rasidence | | | |
| PHYSICI. | PHY | 27. MANNER OF DEATH 1 Metural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c. IN. | JURY AT ORK? YES 2 NO | | HOW INJURY OCCUR | ED |
| TTENDII A affer de 15 15 15 15 15 15 15 15 15 15 15 15 15 | TED | 2 Accident Investigation 3 Suicide 8 Could not be detarmined | 28s. PLACE OF INJURY — building, atc. (Specify | - At home, term, a | | | 281. LOCATION City or Town | (Street and Number or in, State) | Bural Route Number, |
| AL OR | 귤 | 29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN 2 PMEDICAL EXAMINER: Or | | | | | | | euse(a) and manner as stated. |
| TO THE HOSPIT TO THE FUNERA De fied within 7 | BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 . | | | 29c. LICENSE NUI | MBER | 29d. DATE SI | GNED (Month, Day, Year) |
| ₽ ₽ % X | 2 | 30. NAME AND ADDRESS OF PERSON WHO CO | MPLETED CAUSE OF DEAT | | | 404 | 2 2 -11 | > Ma | 756 71 |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRANS SIGNAT | | 214 | دى دي | Corsi | N AW | Bethal |
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Dr. Edward P. Riuli, M.D.

31. DATE FILEO (Month, Day, Year)

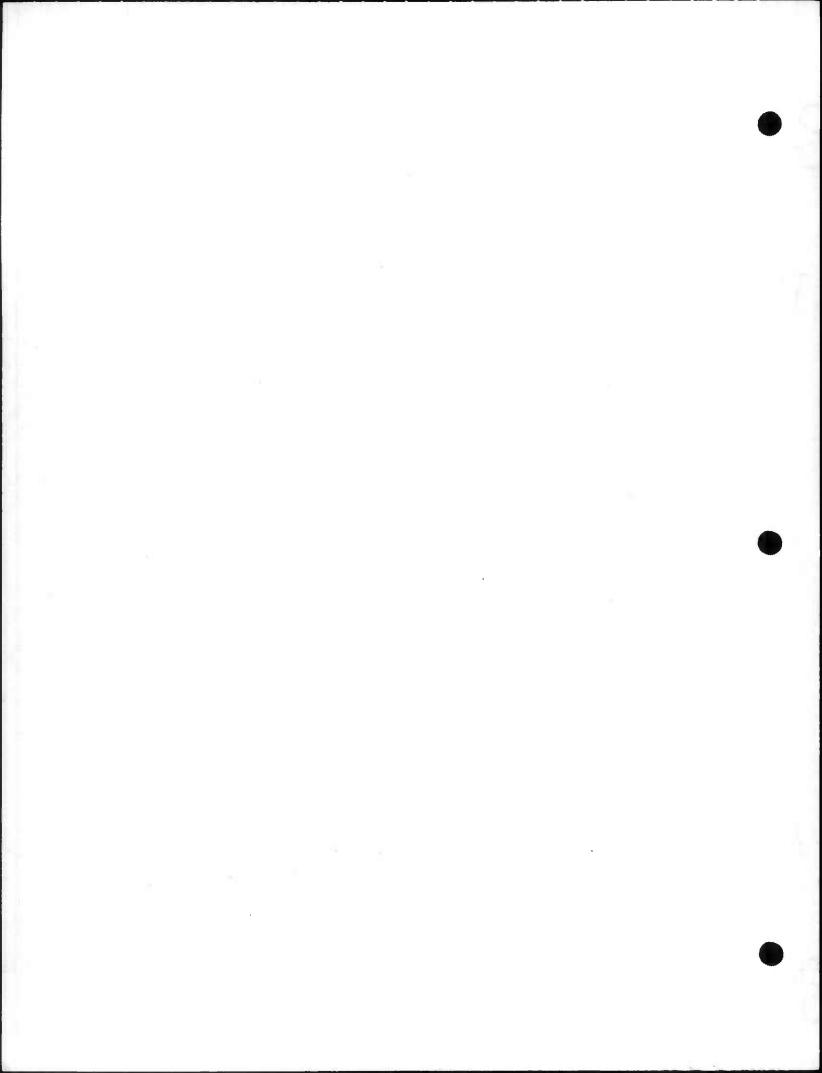
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| | 1 - FOR STATE REGISTRAR | | STATE OF MA | | | | | HEALTH AND | MENT | AL HYGIEN | | | | |
|--------------|---------------------------------------------------|------------------------------|---------------------------------|------------------------------|--------------|-----------------------|---------------|----------------------|----------|-------------------------------------|--------------|-------------|-----------------------------------|---|
| 1 | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | TE OF DEATH | | | 3. TIME OF DEATH | |
| 1 8 | I J | ra | Newton | War | ner | | | | | gust 21 | 19 | 95 | 10:52 P W | Æ |
| | 4. SOCIAL SECURITY NUMB | ER | | 6. AGE (In yrs. le: | st birthday) | IF UNDER 1 | | IF UNDER 24 HRS. | 7. DAT | TE OF BIRTH | Í | 8. BIRTH | PLACE (State or Foreign | • |
| | 218-30-890 | | DELM 2 F | 83 | YRS. | MONTHS | DAYS | HOURS MIN. | | b. 10, | 1912 | | ryland | |
| - | 9a. FACILITY NAME (If not ins | stitution, give s | street and number) | | | 96. CITY, T | TOWN | OR LOCATION OF D | EATN | | 9c. COUN | TY OF DE | ATN | |
| СТОВ | Frederick | Memor | rial Hospi | ital | | Fr | red | erick | | | F | rede | rick | |
| DIREC | 10a. STATE | 10b. COUNT | Y | | 10c. CIT | Y, TOWN OR | LOCA | TION | | | | | 10d. INSIDE CITY | |
| ā | Maryland | Free | derick | | Re | ocky | Ri | dge | | | | | LIMITS? | |
| A L | 100. STREET AND NUMBER | | | | | | 10 | r. ZIP CODE | | | 10g. CITIZ | EN OF W | HAT COUNTRY? | • |
| FUNERAL | 10045 Long' | s Mil | l Road | | | | | 21788 | | | Unit | ed S | tates | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDENT FDRCES? 1 | EVER IN U.S. AR | RMED | 13. W | AS DEC | CENDENT OF NISPA | NIC ORIG | GIN? (Specify Yes | or No- | 14. RACE | - American Indian, White, etc. | |
| B | 1 Never Married 2 3 Widowed 4 Divor | | IF YES, GIVE WA | R DR OATES | | | | Decity Cuban, Mexico | | o Mican, etc.) | | | White | |
| 8 | 15. DECE (Specify only | EDENT'S EDU highest grade | CATION completed) | 16a. DE | CEDENT'S | USUAL OCC | CUPATIO | ON ost of working | 1 | 66, KIND OF BU | SINESS/INDU | JSTRY | | • |
| Ü | Elementary/Secondary (0- | -12) | College (1-4 or 5+) | lite | . Do NOT u | se retired.) | | • | | | | | | |
| COMPLET | 3 | | | | Farr | ner | | | | Own | | | | |
| | 17. FATHER'S NAME (First, Mile | | | | | | | 18. MOTHER'S NA | | | | | | |
| BE | Charles W | arner | | 1 | | | | Blanc | | Stitle | | | | |
| 2 | Shirley An | , | 7 | | | | | and Number or Rural | | | | | 01700 | |
| | 24. METHOD OF DISPOSITION | | 3 | | | Colon OF DISPOSITI | _ | | 1 | nont, Ma | | | 21788 | |
| | 1 Buriel 2 Cremetion 4 Donation 5 Other | n 3 🗆 Rem | oval from State | cametery, cre | emalory or o | Mem. | Car | rdono | 8/25 | | CATION — C | | , | |
| | 21. SIGNATURE OF FUNERAL | The second second | censes / | TRESCIE | aven | 22. NA | AME AI | NO ADDRESS OF FA | O/ZJ | 79.P F. | reder. | ICK, | Maryland | |
| | Hanny | 1.00 | Lavorg | 0 | | 104 | 4 E | . Main S | tree | t Thu | rmont | , MD | Homes, P.A 21788 | 4 |
| | 23 PART Enter the dis | sesses, or o | complications that | ceused the da | ath. Do | not enter th | he ma | ode of dying, suc | ch aa ca | ardiac or reepi | iratory arre | et, | Approximate | |
| 1 1 | IMMEDIATE CAUSE (Fine | | A | o on eech mie | | | | 1 | | | | | Onset and Daath | |
| | disease or condition resulting in death) | + | . Acc | ite 1 | Miss | N/Ma | du | I Tu- | for | the | | | | |
| | | | DUE TO | OR AS A CONSE | DUENCE D | Ð:/ | | | 1 | | | | | - |
| N | Sequentially list condition | ons. | b. /+ | Mic | | tem | SL | 1 | | | | | | |
| F | If any, leading to immed cause. Enter UNDERLYIF | liete | DUE TO (C | R AS A CONSE | DUENCE O | F): | 1 | 2 | | | | | | |
| | CAUSE (Disease or Injur | | c. DIJE TO 48 | A CONSE | > M | 2000 | el. | 5 | | | | | | |
| ERTIFICATION | that initiated eventa resulting in death) LAST | | 552.10 | 15 50 N | | r): // | A | tu de | | | | | 500 | |
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| 됩 | PART II. Other significer | nt condition | a contributing to d | eeth but not r | eaulting | in the unde | erlying | g ceuse given in | Part i. | 24a. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS | , |
| EDIC | | | | | | | | | | 1 TYES 2 | | | COMPLETION OF CAUSE OF DEATN? | |
| : MEC | | | | | | | | | | | | | 1 YES 2 ND | |
| | DID TOBACCO US | SE CONTI | RIBUTE TO CAU | SE OF DEA | TH YE | S I NO | 0 [| UNCERTAI | NZ | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | 26. PLAC | E OF DEA | TH (Check onl | ily one) | | | | | | | |
| YSI | 1 TES 2 ND | | Inpatient 2 🗆 t | ER/Outpatient 3 | □ DDA | OTHER: | ng Hom | ne 5 🗆 Rasidence | 8 🗆 Ott | her (Specify) | | | | |
| PHY | 27. MANNER OF DEATH | 200000 | 28a. DATE OF IN (Month, Day, | JURY Year) | 28b. TIM | IE OF 20 | 8c. INJ WO | IURY AT | 28d. D | EȘCRIBE NOW II | NJURY OCC | JRED | | - |
| B⊀ | | Pending nveatigation | | | | | 1 🗆 1 | YES 2 ND | | | | | | |
| ED | | Could not be | 28s. PLACE OF building, at | INJURY At ho c. (Specify) | me, ferm, | street, factory | y, offic | 8 | | CATION (Street atty or Town, State) | | or Rural Ro | oute Number, | • |
| | | letsrmined | | | | | | | | | | | | |
| COMPLET | | | CIAN: To the best of m | | | | | | | | | | | 4 |
| Š | 2 MEDIC | CAL EXAMINE | R: On the basis of exe | mination and/or i | inveatigatio | on, in my opir | inion, d | leath occured at the | time, da | its and place, an | d dus to the | cause(s) | and menner as stated. | |
| BE | 296. SIGNATURE AND TITLE | CENTIFIES | DD. | | | | | 29c. LICENSE NUI | | 6 | 29d. DATE | SIGNED | Month, Day, Year) | |
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| | 30 NAME AND ADDDESS OF | DEDODN WILL | | | | | | | | | | | | ı |

11, M.D. 310 West 9th Street Frederick, MD

32. REGISTRAR'S SIGNATURE

July Musicar Review



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| | | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | RTMENT OF H | IEALTH AND DEATH | MENTAL HYGIE REG. N | | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) Bettie Ruth | Ward | | | | 2. DATE OF DEATH MONTH AUGUST 20 |), 1995 | 3. TIME OF DEATH 10:00P |
| Pio | | | 1 M 2 K F 7 | (n yrs. lest birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 24, | | BIRTHPLACE (State or Foreign Country) North Carolina |
| UZU physician. burial-transit permit. Pages 1, 2, 3 should | RECTOR | Prince George's H | | ter | Chever | OR LOCATION OF D | PEATH | Prince | e George's |
| Pages | DIREC | 10a. STATE 10b. COUNTY Maryland Prince | George's | | itol Hei | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 🛣 NO |
| nsit permit | FUNERAL | 10e. STREET AND NUMBER 711 Ritchie Road | occigo o | | 101 | 1. ZIP CODE 20743 | | | of WHAT COUNTRY? |
| | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 X NO | If yes, sp | CENDENT OF HISPA ecity Cuben, Mexic 2 X NO Speci | NIC ORIGIN? (Specity on, Puerto Rican, etc.) | Yea or No- 14 | RACE — American Indian, Black, White, atc. Specify: |
| A fe se | COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade on Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of life. Do NOT u | USUAL OCCUPATION Work done during mose retired.) | ON ast of working | 16b. KIND OF E | BUSINESS/INDUS | |
| the hospital or detached for u | OMPL | 12 17. FATHER'S NAME (First, Middle, Last) | Conlege (1-4 or 5+) | Homemak | er | | Own ho | | |
| ま 四位 | BE C | Saint | Jer | nigan | | Margie | | Duk | |
| y be retained age 5 should be notified | 2 | Bettie Jean Turne | r (Daughter) | | as # 10 | | Route Number, City or T | bwn, State, Zip Co | de) |
| ge 6 may be frector, page (| | 20a. METHOD OF DISPOSITION OC Burlet 2 □ Cremetion 3 □ Remove 4 □ Donation 5 □ Other (Specify) | History State | PLACE AND DATE | of disposition (Na ther placa) Cemeter | y | | LOCATION — CITY LOSKIE, | |
| and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | | 21. SIGNATURE OF PUNERAL SERVICE LICES | | 0827 | Rapp | | L Services | | |
| ted within 24 hours after completely filled in by the ial, cremation, or removal : event, the medical | | 23. PART I. Enter the diseases, or co- ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) | st only one cause on ea | ich line. | not enter the mo | de of dying, suc | Silver | Spring | MD 20910 Approximate Interval Between Onset and Death 3 days |
| ficate be executed physician and con ne prior to burial. | RTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | |
| the atter Mental | CAL CER | PART II. Other aignificant conditions | contributing to death bu | it not resulting | In the underlying | g cause given in | Part I. 24a. WAS / | AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| ires that signed b leafth ar | MEDIC | Chronic Pancreati Subarachnoid hemo | | | | | 1 TYES | ORMED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| law rec as beer Dept. of | AN: W | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL | BUTE TO CAUSE OF | DEATH YE | S 🗆 NO 🗆 | UNCERTAI | N 🗆 | | 1 TYES 2 X NO |
| PHYSICIAN: The this certificate h with the State I | SICI | EXAMINER? | HOSPITAL: X Inpetient 2 ER/Outpu | | TH (Check only one) OTHER: 4 Nursing Hom | e 5 🗆 Residence | 6 Other (Specify) | | |
| DING PHYSII After this co death with t | ву рну | 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | JURY WO | URY AT RK? 'ES 2 NO | 28d. DESCRIBE HOW | / INJURY OCCUR | ED |
| TTENDI CTOR: A after de 28 Is | <u>n</u> | 3 Suicide 8 Could not be determined | 26e. PLACE OF INJURY building, etc. (Speci | At home, farm, (| street, factory, office | | 281. LOCATION (Stree City or Town, Stat | ot and Number or i | Rural Route Number, |
| TAL OR VAL DIRE 72 hour | COMPLET | | AN: To the best of my knowle | | | | | | Nutrice and manner as stated |
| 표표를 | 핆 | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D25079 8-23-9: | | | | | | | |
| 668₹ | 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, | Print) | 520070 | | 0- | E0-00 |

Seabrook, MD

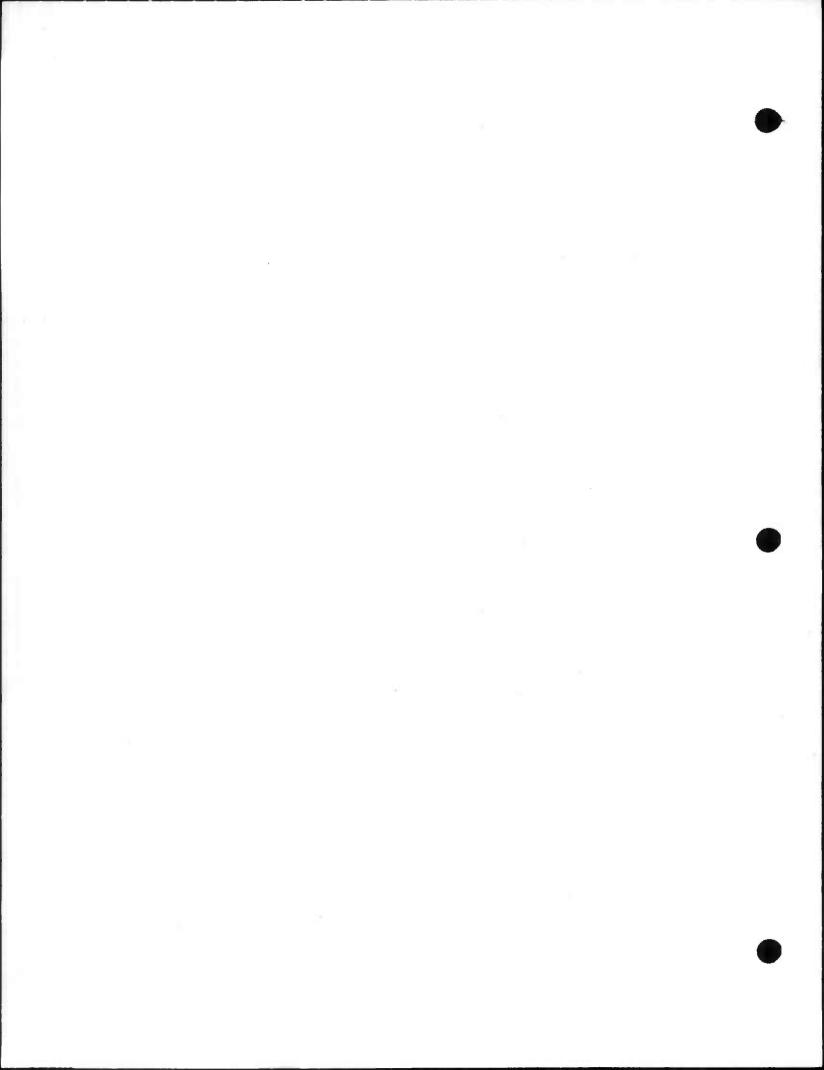
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Don H. Yablonowitz, 7404 Executive Pl.

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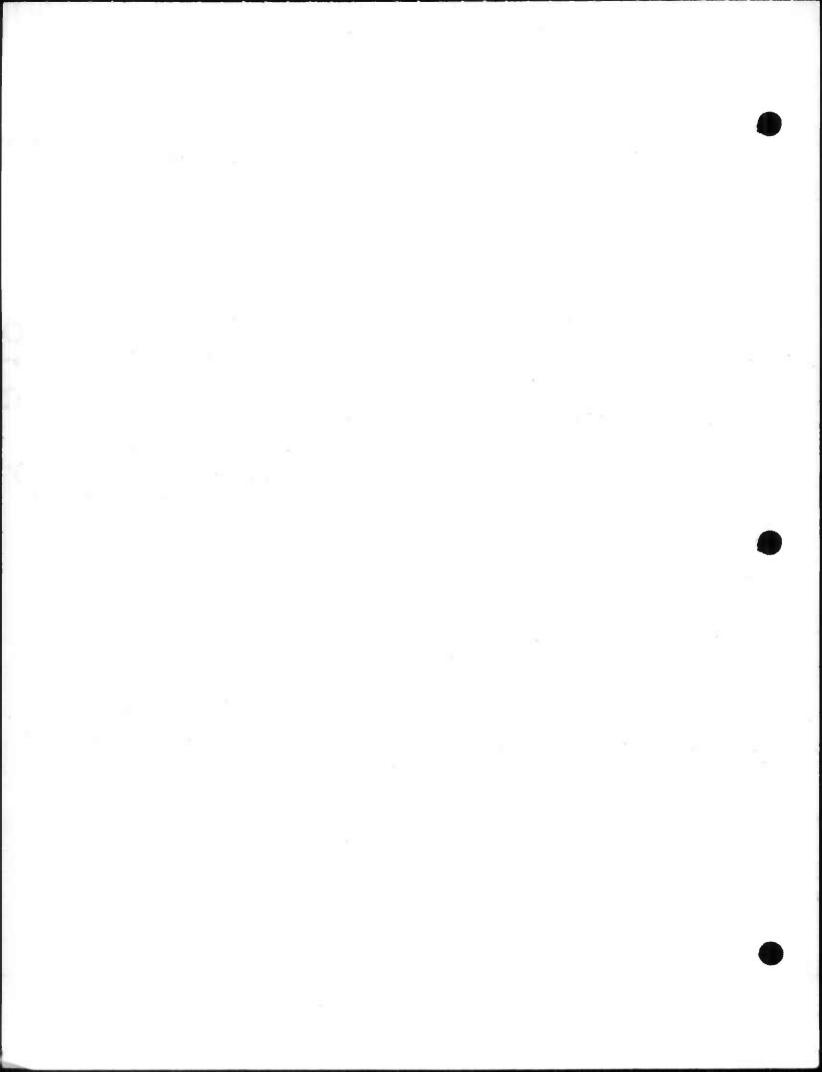
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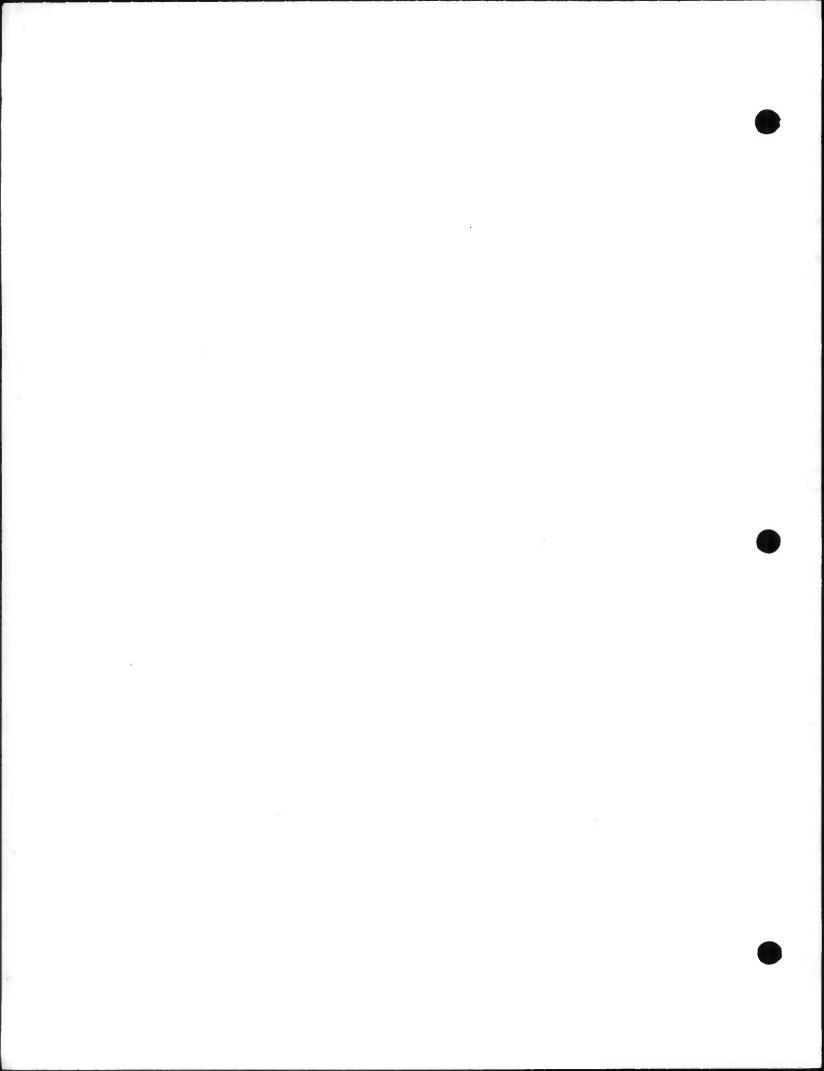
DHMH-16 Rev 1/89

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | | | MENTAL HYGIEN | | | | | |
|------------------------------------------------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------|------------------------|-------------------------------|--------------------------------------------------------------------------------|----|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) | e Wilson | | | | 2. DATE OF DEATH | MY | YEAR 3. T | TIME OF DEATH | P | |
| Pin | | 4. SOCIAL SECURITY NUMBER 577 30 7457 | 5. SEX 6. AGE (In | yrs. leet birthday) N YRS. | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) MAY 8, 1 | 10 | BIRTHPLAC Country) VIRG | CE (State or Foreign | m | |
| . 2, 3 should | стов | 8015 MAPLE AVE | | | | MA PARK | | | TY OF DEATH | | | |
| if. Pages 1, | DIRE | 10a. STATE 10b. COUNTY | Υ | | TOWN OR LOCAL | ON, D.C. | | | | . INSIDE CITY LIMITS?] YES 2 [] NO | | |
| an. ransit permit. | NERAL | 100. STREET AND NUMBER 213 FARRAGUT S | | | | 20011 | | | U.S. | | | |
| 215-0020 attending physician. Ise as the burla-transit | BY FUNE | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or If yes, specify Cuben, Mexicen, Puerto Rican, etc.) | | | | | | | |
| 21 for the | PLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 +) | 16e. DECEDENT'S US (Give kind al was life. Do NOT use HOMEN | rk done during mo retired.) | ON est of working | 16b. KIND OF BU | HOUSE | | | | |
| YLA by the be def | E COMPL | 17. FATHER'S NAME (First, Middle, Lest) FRANKLIN HI | II | | | | ME (First, Middle, Malden | Surname) | | | | |
| A be retained by be retained page 5 should be notified | TO B | 190, INFORMANT'S NAME (Type/Print) VEDA WIISON | | | DDRESS (Street of SAME AS | | Route Number, City or Tow | n, State, Zip Co | ode) | | | |
| AORE e 6 may rector, pa must b | | 20e. METHOD OF DISPOSITION CDBurlet 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | eval from State | PLACE AND DATE OF tery, crepnatory or othe IINCC | SIN CE | METERY | AUG. 22, 199 | cation — cir 5 BREI | ty or Town, B | nate D, MD. | | |
| death. | | + Mustant - | 7 Besta | | TAKON ST N | W. WAS: | RAL HOME HINTGON. | D.C. | 2001 | CARROL 12 | L | |
| for within 24 hours after completely filled in by the ial, cremation, or removal event, the medical | | IMMEDIATE CAUSE (Final | List only one cause on eed | ch line. | | | | iratory arrea | ıt, | Approximate Interval Batwo | | |
| DX 68 be execution to bur | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A CO) DUE TO (OWAS A CO) DUE TO (OWAS A CO) | consequence of: | Inan | ition age Do | mentía | | | Days | | |
| death certificate attending physiemal Hygiene printy, or other to | CERTIF | that initiated eventa reaulting in deeth) LAST | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | | | | | |
| Licordo | MEDICAL | PART II. Other significant condition | a contributing to death bu | t not reaulting in | the underlying | g cause given in | Part I. 24s. WAS AN PERFOR | RMED? | AMAIL COMI OF D | E AUTOPSY FINDIN LABLE PRIOR TO PLETION OF CAUS DEATH? YES 2 10 NO | | |
| Sept by L | SICIAN: 1 | DID TOBACCO USE CONTR | 20 | 8. PLACE OF DEATH | (Check only one) | UNCERTAIN | X | | | | | |
| SICIAN: The Sician the State or Item | PHYSI | 1 SAZES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Output 28e. DATE OF INJURY | tlent 3 DOA 4 | | e 5X Reeldence | | | | | | |
| ATTENDING PHYSICIAN: The ECTOR: After this certificate his safter death with the State D 128 is marked, or item? | ВУ Р | 1 Stellural 5 Pending Investigation | (Month, Day, Year) | 26b. TIME (| M 1 1 | RK? /ES 2 NO | 28d. DESCRIBE HOW I | | | | | |
| OR ATTEND DIRECTOR: / hours after of item 28 is | ETED. | 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY – building, etc. (Specif) | <i>''</i> | | | 28f. LOCATION (Street of City or Town, State) | | | Vumber, | | |
| 4 42 = | COMPLETE | (Check only one) 2 MEDICAL EXAMINE | CIAN: To the best of my knowled R: On the basis of examination of | | | | | | | manner ee stated | ś. | |
| TO THE HOSPIT TO THE FUNER De filed within 7 | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | no | | | D 3 7 | | 29d. DATE S | 19/9 | | | |
| ´ | | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEAT | Cocenus | rine) | Dive 1 | Greenbeld | 4 1 | 200 | 7.0 | | |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNAT | | 0 / | | STEP BED | 1.0 | 201 | , 0 | | |



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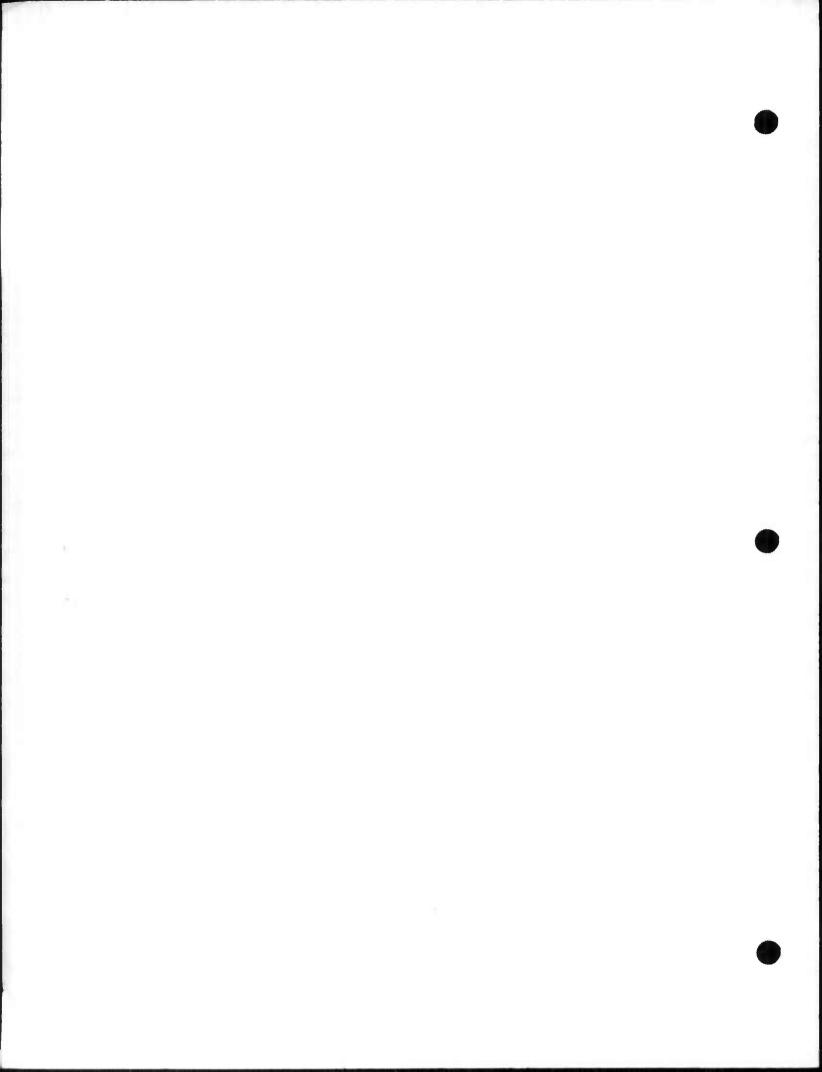
| | | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYL | AND / I | DEPART RTIFI | TMENT CATE | OF H | EALTH AND | MENT | AL HYGIEN | | | | |
|----------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------|------------|------------------------------|------------------------|---------------|---------------------|-------------------------------------------------------|----------------------|---------------------------------------|----------------------------------|-----------------------|------------------------------------------------------------|-------------------|
| | | 1. DECEDENT'S NAME (First, CAROLINE | | CHWAB | | | LLIAN | | | | 2. DAT MON AUG | E OF DEATH | | YEAR 3. | TIME OF DEA | |
| 2 | | 4. SOCIAL SECURITY NUMBER 082.07.8588 | | 5. SEX 1 M 2 F | | (In yrs. lest i | | IF UNDER 1 | YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DAT | E OF BIRTH | | | ACE (State or F | |
| . 2, 3 should | TOR | 98. FACILITY NAME (# not in 10450 LOTTS) RESIDENCE OF DEC | FORD | | | | | | | R LOCATION OF D | EATH | | 9c. COUNT PRINCE | | | |
| permit. Pages 1, | DIRECTOR | 10a. STATE MARYLAND | 10b, COUNT | CE GEORGI | ES | | | TOWN OF | | | | | | 1000 | INSIDE CIT | |
| ist. | FUNERAL | 10450 LOTTSE | ORD R | | | | | | - | 20721 | | | 10.00 | N OF WHA | T COUNTRY? | |
| attending physician. se as the burial-transit | ВУ | 11. MARITAL STATUS 1 Never Married 2 4 3 Widowed 4 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES | 2X NO | ED) | - 11 | yes, spe | ENDENT OF HISPA Icity Cuben, Mexico 2. NO Speci | en, Puerto | IN? (Specify Yes Rican, etc.) | or No.— 14 | Black, W Specify N | American ind Thite, atc. JHITE | ien, |
| 8 2 | PLETED | 15. DEC (Specify only Elementary/Secondary (0 | EDENT'S EOU highest grade | CATION completed) College (1-4 or 5 - | ·) | (Glvs life, D | edent's use wo NOT use | - | CUPATIO ring mos | PN st of working | 16 | Own Ho | | TRY | | |
| by the hospital be detached to at once. | E COMPLET | 17. FATHER'S NAME (First, MI | odle, Lest) | | | nome | make | 1 | | 18. MOTHER'S NA | | Middle, Malden | | | | |
| retained 5 should notified | TO BE | 198. INFORMANT'S NAME (7) | /pa/Print) | | | | | | | nd Number or Rurel RD RD. M | Route Nui | mber, City or Town | | | 1721 | |
| e 6 may be rector, page must be | | 20a. METHOD OF DISPOSITI 1 | n 3 🗌 Rem | oval from State | | PLACE AN | ID DATE OF | FDISPOSIT | ION (Nat | me of | 8/2 | TE 20c. LO | CATION — CH | y or Town, | State | |
| ter death. Page 6 m the funeral director, wal. | | 21. SIONATURE OF PUNERAL | SERVICE LIC | n fet | 119 |) | | | | WISCONSI | | JOSEPH E. N.W | | | - | J. |
| ted within 24 hours after completely filled in by the ial, cremation, or removal : event, the medical | | 23. PART / Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death) | ert railure, | a. C | C C | ach line. | - 0 | | | de of dying, suc | | rdiac or reapi | ratory arres | t, | Approxim Interval B Onset and | etween d Desth |
| certificate be executed nding physician and corr hygiene prior to burial, or other traumatic en | CERTIFICATION | Sequentially list condition of any, leading to immediate the cause. Enter UNDERLY!! CAUSE (Disease or injusted initiated events resulting in death) LAS | liete NG ry | DUE TO | (OR AS A | CONSEQU | ENCE OF) | | | | | | | | | |
| that the cet by the the and Me any injur | MEDICAL CE | PART II. Other significan | | a contributing to | death b | ut not rea | ulting in | the und | erlying | cause given in | Part I. | 24a. WAS AN PERFOR | MED? | CO | TRE AUTOPSY F AILABLE PRIOR IMPLETION OF (DEATH? | TO |
| of of | PHYSICIAN: M | DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? | | | | F DEATI | | | | UNCERTAI | N 🗆 | | | 1 (| YES 2 | NO |
| PHYSICIAN: The lanthis certificate has with the State Depreted, or item 23 | HYSIC | 1 YES 2 DATO | | HOSPITAL: 1 Inputient 2 I | _ | | | | | 8 🗆 Residence | | | | | | |
| | ВУ | 1 Natural 5 1 | Pending nvestigation | (Month, De | my, Year) | | INJUI | RY M | | ES 2 NO | | SCRIBE HOW IF | | | | |
| OR ATTENDING DIRECTOR: After hours after death item 28 is ma | ETED | 4 Homicide | Could not be letermined | building, | etc. (Spec | elly) | | | | | C/h | CATION (Street a r or Town, State) | | HURN HOUR | Number, | |
| TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If IN | COMPLET | (Check only one) 2 MEDIC | CAL EXAMINE | CIAN: To the beat of R: On the beats of as | my knowi | ledge, daati n and/or inv | eatigation, | at the tim | nion, de | ath occured at the | time, dat | suse(s) and man | ner as atated, d dus to the c | Buse(s) An | d manner as s | tated, |
| TO THE TO THE De filed IMPOR | TO BE | 29b. SIGNATURE AND TITLE Jole Jole Jole Jole Jole Jole Jole Jole | 1- | | | ind i | / | | | D 25 | O 7 | 9 | ≥ DATE S | PRED (MG | onth, Day, Year) | |
| | | DR. DON YAB | LONOW] | TZ 740 | 4 E | KECUT | IVE : | | E # | 502 SE | ABRO | OK, MD | . 2070 | 6 | | |
| | | 31. DATE FILED (MONT), Day, | 1005 | 3. REGISTRA | R'S SIGN | ATUBE | 11. | | | | | | - | _ | | |



DHMH-15 Rev 1/89

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| BALTIMORE, MARYLAND 2 | 24 hours after death. Page 6 may be retained by the hospital of |
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| | | | FOR STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMENT ERTIFICATE | OF HEALTH AND | MENTAL HYGIEN | | | | | |
|--------------------------------------------------------------------------------------------|--------------|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------|-----------------|-----------------|-------------------------------------------------------------------------------------------|-----|--|
| | | | 1. DECEDENT'S NAME (First, Middle, Lest) Walter | · William | 5 | | 2. DATE OF DEATH MONTH A 4 94 5 + | 20 19 | EAR . | THE OF DEATH | М | |
| pi | | l | 4. SOCIAL SECURITY NUMBER 218-24-6819 | 5. SEX 6. AGE (In yrs. last 1 ☑ M 2 ☐ F 6 6 | YRS. MONTHS | DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) OCt. 28, | 1928 | BIRTHPLA | CE (State or Foreign | , | |
| 2, 3 shor | | CTOR | 9a. FACILITY NAME (if not institution, give sti HOLY Cross Hosp RESIDENCE OF DECEMENT | | | ilver Spr | | 9c. COUNTY | | OMERY | | |
| Pages 1, | | # # | 10a. STATE 10b. COUNTY | tgomery | 10c. CITY, TOWN O | r Spring | | | 100 | INSIDE CITY LIMITS? YES 2 NO | | |
| ısit permit | | FUNERAL | 100. STREET AND NUMBER 3119 Fairland R | | DIIVO | 101. ZIP CODE 20904 | 1 | N OF WHAT | F WHAT COUNTRY? | | | |
| 215-0020 attending physician. se as the burial-transit permit. Pages 1, 2, 3 should | | BY FUN | 11. MARITAL STATUS 1 📉 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 X YES 2 N IF YES, GIVE WAR OR DATES KOrean War | 10 1 | MAS DECENDENT OF HISPA f yes, specify Cuban, Maxic YES 2 NO Speci | en, Puerto Rican, atc.) | | RACE - / | American Indian. | | |
| 2121 If or after for use | | LETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | completed) (Gi | CEDENT'S USUAL OC ve kind of work done of Do NOT use retired.) | CCUPATION Juring most of working | 16b. KIND OF BU | SINESS/INDUS | TRY | | | |
| YLAND 2 by the hospital be detached to | | COMPL | 11th 17. FATHER'S NAME (First, Middle, Lest) Frank E. Willi | | rator Si | | ME (First, Middle, Maider | | | | _ | |
| MAR retained 5 should | notified | O BE | 196. INFORMANT'S NAME (Type/Print) Christine E. W: | 198 | | Dora (Street and Number or Rural Fairland | | | | 0904 | | |
| TIMORE, n. Page 6 may be and director, page | must be | | 20a. METHOD OF DISPOSITION 130 Burlel 2 Cremation 3 Remo | 20b. PLACE A | ND DATE OF DISPOSE matory or other place) Lawn Mer | ITION (Name of | | OCATION — City | y or Town, S | Stata | | |
| AL fund | examiner | | 21. BIGMATETRE CAPTUMERAL SERVICE LICE | Bumble | lu Si | NAME AND ADDRESS OF FUN NOWDEN FUN OCKVIIIF: | IERAL HOM | E, P. | Α. | MD | | |
| withing hours at pietely filled in by companied | rent, the m | | IMMEDIATE CAUSE (Final | Jungal Pe | utonit | his | | fratory arrest | . | Approximate Interval Betwee Onset and Dec | ath | |
| ficate be execuply sician and | traumatic | HILLAHON | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CONOMIC Renal Failure. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| S, P death | 5 6 | 3 | PART II. Other algnificent conditions | Contributing to death but got a | (|) 1 | | 18/6/1 | | 12 yr | ာ. | |
| COR ires that it signed by teatth and | us any | MEDICAL | | Continuiting to death but not h | sediting in the diff | denying cause given in | Part I. 24s. WAS AN PERFO | RMED? | CON OF E | IE AUTOPSY FINDING ILABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 \(\tau\) NO | | |
| AL I | Item 23 st | AN: | DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLAC | TH YES N | | N 🗆 | | | | | |
| F 55 55 # | 1, or ite | TSICIAN | 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Sinpatient 2 ER/Outpatient 3 28s. DATE OF INJURY | 26b. TIME OF | t: ling Home 5 - Residence 28c. INJURY AT | 6 ☐ Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | erD. | | | |
| ON OF DING PHYSIC After this cer | marke | | Natural 5 Pending 2 Accident investigation | (Month, Day, Year) | INJURY M | WORK? | | | | | | |
| ISI TEN TOR: | 00 L | | 3 Suicide S Could not be determined | 28e. PLACE OF INJURY — At hor building, atc. (Specify) | ne, tarm, atreet, tacto | ory, office | 281. LOCATION (Street City or Town, State | and Number or i | Rural Route | Number, | | |
| DIV HOSPITAL OR A FUNERAL DIREC | INT: If item | COMPLE | | IAN: To the best of my knowledge, des | | | | | ause(a) and | manner as stated. | ١. | |
| TO THE HOSPITAL (TO THE FUNERAL DAS FLACE WITHIN 27 P. P. P. P. P. P. P. P. P. P. P. P. P. | IMPORTANT: | i i | 29b. SIGNATURE AND TITLE OF CERTIFIER | mo. | | 29c. LICENSE NU | MBER 871 | PAUA | Just Mon | th, Day, Year) | 5 | |
|) | | | 30. NAME AND ADDRESS OF PERSON WHO A RAJVAN SHI | COMPLETED CAUSE OF DEATH (ITEM | 9 Yessiur | D37 | 09 Rock | ville 1 | mpx | >904 | | |
| | | | 31. DATE FILED (Month, Day, Year) AUG 23 1005 | 32. REGISTRAR'S SIGNATURE | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| 1. DECEDENT'S NAME (First, Middle, Last, |) | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH |
| Elizabeth Clagg | ett Zichterm | an | | | August | - 18 | | 995 | 10:00 p |
| 4. SOCIAL SECURITY NUMBER | 7 | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | | 8. BIRTH | HPLACE (State or Foreign |
| 159-34-6308 | 1 🗆 M 2 🔀 F 5 | 4 YRS. | MONTHS DAYS | HOURS MIN. | July 9 | | 1/. 1 | Counti | 77) |
| 9e. FACILITY NAME (If not institution, give | street end number) | | 9b. CITY, TOWN (| OR LOCATION OF DI | | , 15 | | INTY OF D | yland |
| | | Homo | | | | | 10000 | | |
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| Maryland Prince | ce George's | | College | Park | | | | | LIMITS? |
| 100. STREET AND NUMBER | | | | 1. ZIP CODE | | | 10g. CIT | IZEN OF V | WHAT COUNTRY? |
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| 5817 Swarthmore 11. Markital status | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS DEC | CENDENT OF HISPAN | NIC ORIGIN? (S | nacify Yes | | S.A. | E — American Indian |
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| 3 Wildowed 4 Divorced | | DAILS | I I TES | 2 KI NO Specin | у: | | | Speci | White |
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| 12 | | Secreta | rv | | Go | vern | ment | | |
| Specify only highest grad [Specify only highest grad [Elementary/Secondary (0-12)] 1 2 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | | | | | |
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| M INCOMMENTS NAME (To - CO/ot) | | 19h MAII INC | ADDRESS (Street of | and Number or Rural I | | | Otesta Ti | 0-4-1 | |
| Joseph T. Zichte | rman | | | | | | | | 00/1/ |
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| shock or heart fellure | complications that cause | ed the death. Do | not antar the mo | Baltimor | e Ave. has cardiac | or reapl | ratory an | rest, | Approximata |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 OFCEOENT'S NAME (First Middle Last) 2. DATE OF OEATH 3. TIME OF DEATH Robert Aro Sept. 7, 1995 10:00 A.M 7. DATE OF BIRTH
(Month, Day, Year)
june 3,1916 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 9. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. 17 M 2 - F 79 212-09-6036 Maryland 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1809 Covington St. DIRECTOR Balto.City, Md. none RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Balto.City, Md. Maryland none 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 100 CITIZEN OF WHAT COUNTRY? 21230 United States 1809 Covington St. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Norried BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUSTRY (Specify only highest grade completed) Flementary/Secondary (0-12) College (1.4 or 5.4) Superintendent Parks, City of Balto. 5th.Grade none 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Couch Annie notified at George Aro BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 1809 Covington St. Balto. Md. 21230 Mrs.Mary M.Aro e 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c i OCATION - City or Town State DATE A Donation 5 Other (Specify) must Cedar Hill Cemt. 9/11/95 A.A.Co.Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Balto.Md. 21230 McCully Funeral Home, 130 E. Fort Ave medical 23. PART I. Entsr the disesses, or complications that ogused the desth. Do not sater the mode of dying, such as cardiac or respiratory arrest, ahock, or heert fellure. Liet only one ceuse on each line. Interval Batween IMMEDIATE CAUSE (Finel Onset and Death disease or condition CVA resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Chilliani or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO amy COMPLETION OF CAUSE 1 TYES 2 LINO shows 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DONCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) item EXAMINER? certificate h the State HOSPITAL: OTHER:
4 Nursing Home 5 Realdence 6 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 26a. PLACE OF INJURY — At home, farm, street, fectory, office building, atc, (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 28 4 Homicide Hem 29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, end due to the cause(a) and manner es stated. -2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 29b, GRATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 019329 ► 9 (7/55 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H MERSEY AMB5 6565 N.CHARLES ST 21204 BALT, NO 32 REGISTRAR'S SIGNATURE

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BALTIMORF MARYI AND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760

| BALLIMONE, MARTLAND ZIZIS-0020 | BALLIMONE, MANTLAND ZIZIS-0020 |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | hours after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fills | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | or removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |

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| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | OF DEATH | | | . TIME OF DEATH |
| | MARY ABRAMS | | | | | | | August 26, 1995 | | | 8:50 A M | | |
| | 4. SOCIAL SECURITY NUMBER | 6. SEX 6. | AGE (In yrs. les | t birthday) | | R t YEAR | IF UNDER | | 7. DATE | OF BUILTH | , | | ACE (State or Foreign |
| | 024-28-3686 | ☐ M 2XXF | 97 | YRS. | MONTHS | MONTHS DAYS HOURS MIN. | | | | (Month, Day, Year) Count April 12, 1898 Ru | | | sia |
| | 9a. FACILITY NAME (If not institution, give street | et end number) | | | 9b. CIT | Y, TOWN O | R LOCATI | ON OF DE | | | - | NTY OF OEA | |
| 5 | Holy Cross Hospital | | | | Silver Spring | | | | | | ontgo | mery | |
| | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | | | | 1. | Od. INSIDE CITY |
| DIRECTOR | Maryland Montgomery | | | | Kensington | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | gomery | | 1 1/4 | 2115 1 | | ZIP COD | E | | | 10a. CIT | | TYES 2 NO |
| FUNERAL | 3000 McComas Avenue | | | | | | 208 | 95 | | | | U.S.A | |
| S | | 2. WAS DECEDENT EV | | | 13. | WAS DECI | | | IC ORIGI | 17 (Specify Yes | | | - |
| | 1 Never Married 2 Married | FORCES? 1 T | | io | | If yes, spe | cify Cuba | n, Mexicar Specify | n, Puerto | Ricen, etc.) | | Black, 1 | - Americen Indian, White, etc. |
|) BY | 3 A Wildowed 4 Divorced | | | | | | 30 | -,, | | | | W | hite |
| ed at once. BE COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co. | 'ION mpleted) | 16a. DE | CEDENT'S ive kind of w Do NOT us | USUAL C | CCUPATIO | N it of worldr | 107 | 168 | . KIND OF BUS | INESS/IN | | |
| Ë | | College (1-4 or 5 +) | | | _ | | | | | | . 7 | | |
| a F | 12 Years | | Sa | les I | √oma | n. | | | | Reta | | | |
| 5 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | Middle, Meiden | Sumame) | | |
| 8 8 | Abraham Masicov 19e. INFORMANT'S NAME (Type/Print) | Abraham Masicov Bessie Boze | | | | | | | | | | | |
| 2 | 199. NAFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Downs Drive, Silver Spring, Maryland 20904 | | | | | | | | | | | | |
| 2 | 20e. METHOD OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DISPOSITION 20b. SILACE AND DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF DAYS OF | | | | | | | | | | | | |
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| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE | OI Da | IKEL I | 22. | NAME AN | D AODRE | SS OF FAC | TIAAO | wes | | xbury | |
| examiner must be notified at once. TO BE COM | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. | | | | | | | | | | | | |
| | Conald C. 232 CARROLL ST, NW, WASHINGTON, DC 20012 | | | | | | | | | | | | |
| medica | 23. PART i. Enter the diseases, or complications that ceused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one ceuse on each line. | | | | | | | | | | | Approximats Interval Between | |
| 2 | IMMEDIATE CAUSE (Final disease or condition | 1. | 1 | SP | | | | | | | Onset and Death | | |
| , | disease or condition resulting in death) s. Cardiac Cysuly Kum (a | | | | | | | | | | Munter | | |
| | | | | | | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, b. | DUE TO (OR | AS A COUSEO | OUENCE OF | 462 | y | DI | Xac | 10 | | | | - |
| AT | cause. Enter UNDERLYING | cause. Enter UNDERLYING | | | | | | | | | | | j |
| E E | CAUSE (Disesse or injury that initiated events | DUE TO (OR AS CONSEQUENCE OF): | | | | | | | | | | | |
| | resulting in death) LAST | | | | | | | | | | | | |
| 히 | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | | |
| MEDICAL | Pa e 10:0. | Online to dea | til but not n | esulting it | n the ui | aeriying | cause g | iven in i | Part I. | 24a. WAS AN | | Al | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| | enal funda | e | | | | | | | - 1 | t 🗌 YES 🧎 | No | | OMPLETION OF CAUSE F DEATH? |
| E | TO TOP ACCOUNTS CONTRIBUTE TO CAMPE OF DEATH AND THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY | | | | | | | | | | | | |
| AN S | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF GEATH (Check only one) | | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? | OSPHAL: | | _ | OTHE | R: | | | | | | | |
| <u> </u> | 27. MANNER OF DEATH | 280. DATE OF INJU | | | _ | _ | | sidence (| | | | | |
| - | 1 Natural 5 Pending | (Month, Day, Year) INJURY WC | | | | | URY AT RK? 28d. DESCRIBE HOW INJURY OCCURED RK? 2 □ NO | | | | | | |
| B \ | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF IN. | JURY — At hor | me, farm, at | reet, fac | | | - | 28f. LOC | ATION (Street e | nd Number | or Burni Bou | to Number |
| 1 ED | 4 Homicide 8 Could not be determined | building, etc. | (Specify) | | , , | .,, | | | | or Town, Stete) | IN PROPERTY | or moret 1100 | e montes, |
| E E | 29e. CERTIFIER | | | | | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. | | | | | | | | | | | | |
| 3 - | 29K SIGNATURE AND TITLE OF SETTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | |
| | (186011VIII 1 | XX | 20 | | | | ZYC. LICE | NOE NUM | JU/ | - man | Z9d. DAT | E SIGNED (M | Conth, Day, Year) |
| 2 | 30. NAME AND APORESS OF PERSON WHO C | OMPKETED CAUSE OF | F DEATH (ITEM | 1 27) (Type | Print1 | | 1 | 200 | 176 | | - 0 | 0/46 | 771 |

a. BIRTHPLACE (State or Foreign

Approximata Interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?

10:45am M

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Mae

5. SEX

Brooks

Nellie
4. SOCIAL SECURITY NUMBER

| | | | | | | | | | | 18,1916 Maryland | | | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------|--|--|
| ECTOR | 305 Ma | rgare | | | аь. с | | SEX | EATH | | Balt: | | | |
| DIREC | 109. STATE Md • | 10b. COUNTY | altimore | | IOC. CITY, TOW | . CITY, TOWN OR LOCATION $ \begin{array}{c} \text{10d. ins} \\ \text{Essex} \end{array} $ | | | | | | | |
| ERAL | 305 Mar | | Ave. | | 10 | or zip code 2122 | 1 | 10g. C | 10g, CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUNER | 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 X Div | D | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES ZX NO Specify: Specify | | | | | | | | | | |
| COMPLETED | 15. DE (Specify or Elementery/Secondary | (Give | DENT'S USUAL kind of work do NOT use retire | ne during m | ION lost of working | 16b. K | MArtin | | ietta | | | | |
| BE CON | 17. FATHER'S NAME (First, Will | | Thomas | | | | | die, Meiden Surname Little | | | | | |
| 10 | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Brooks 502 Delaware Ave. Baltimore MD. 2122 | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION Marie 2 Cremation 3 Removal from State | | | | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST d. ATHENOSCLENOSCS | | | | | | | | | | Approxima interval Be Onset and | | |
| MEDICAL | DID TOBACCO | | | ng cause givan ir | PERFORMED? VES 2 NO | | WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION DF CO OF DEATH? | | | | | | |
| SICIAN: | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO | | HOSPITAL: | 26. PLACE | OF DEATH (Ch | ock only one | | | Specify) | | | | |
| ву РНУ | 2 Accident | Pending investigation | 26e. DATE OF INJU (Month, Day, Ye | er) | 26b. TIME OF INJURY | 1 U | JURY AT /ORK? YES 2 NO | | RIBE HOW INJURY | | loute Number | | |
| | 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only one) 2 ME | Could not be datermined | (Month, Dey, Ye 26e. PLACE OF IN. building, etc. NCIAN: To the best of my I | IURY — At home (Specify) | injury farm, atreet, | fectory, off | /ORK? YES 2 NO | 281. LOCAT City or e to the cause e time, date er | COCATION (Street and Number or Rural Route Number, City or Town, State) cause(e) and manner ea stated, date and piece, and due to the cause(e) and manner ea 29d. DATE SIGNED (Mopth, Day, Yes 9 7 7 5) | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

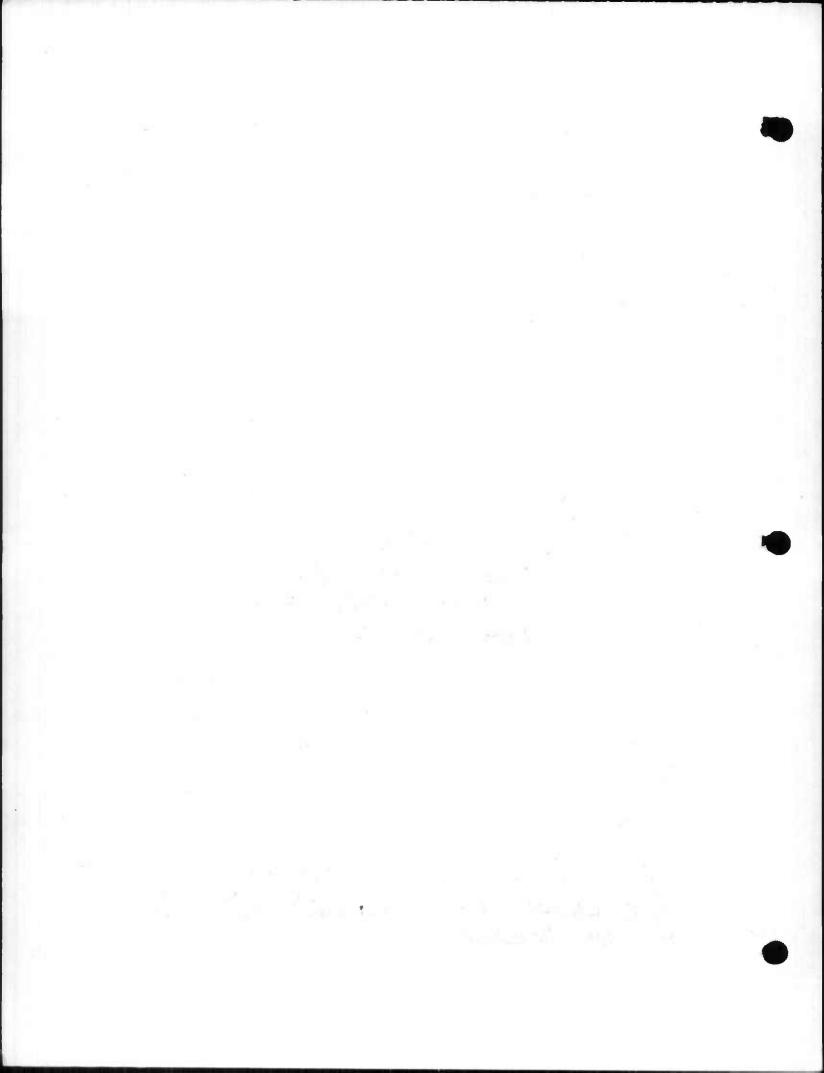
6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

2. DATE OF DEATH MONTH

7. DATE OF BIRTH

Sept.4, 1995

DHMH-16 Rev 1/89



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| may be retained by the hospital or attending physician. | or, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho | ist be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho be filled within 72 hours after death with the State Dent. of Health and Mental Hydiele prior to burial. cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

95 27255 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 6 45 Geyer arl J 5 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS untry) 303-09-9321 1 M 2 - F 21 Endiana 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Manor Care RuyTon DIRECTOR Ballimore lowson 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY INDIANA MARION INDIANAPOLIS 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8813 MADISON AVENUE, C-204 46227 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 INSULIN PRODUCER ELI LILLY 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) BE **JOHN** BEYER RUTH STARR notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 JUDITH A. MORRISON 6348 PERAULT DR., INDIANAPOLIS, IN 46227 ě 20b. PLACE AND DATE OF DISPOSITION (Name of EAST 20e. METNOD OF DISPOSITION
1XX Burlet 2 Cremetion 3 Removal from State 20c. LOCATION - City or Town, State OATE MUST CABLE CAME CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CON 4 Donation 8 Other (Specify) 19-9 INDIANAPOLIS. 21. SIGNATURE OF FUNERAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY Hally STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. BALTIMORE, MD lack 21228 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final **Onset and Death** he disease Dr condition Cure resulting in death) Week DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 1 YES 2 19-NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 TES 2 NO 1 Dipatient 2 ER/Outpatient 3 DOA rsing Nome 8 - Residence 8 - Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRISE NOW INJURY OCCURED 1 Antural 5 Pending Investigation 1 YES 2 NO 87 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stele) 3 Suicide 8 Could not be COMPLETED 4 Nomicide 29e. CERTIFIER

(Chart ank)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ea stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(e) and manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

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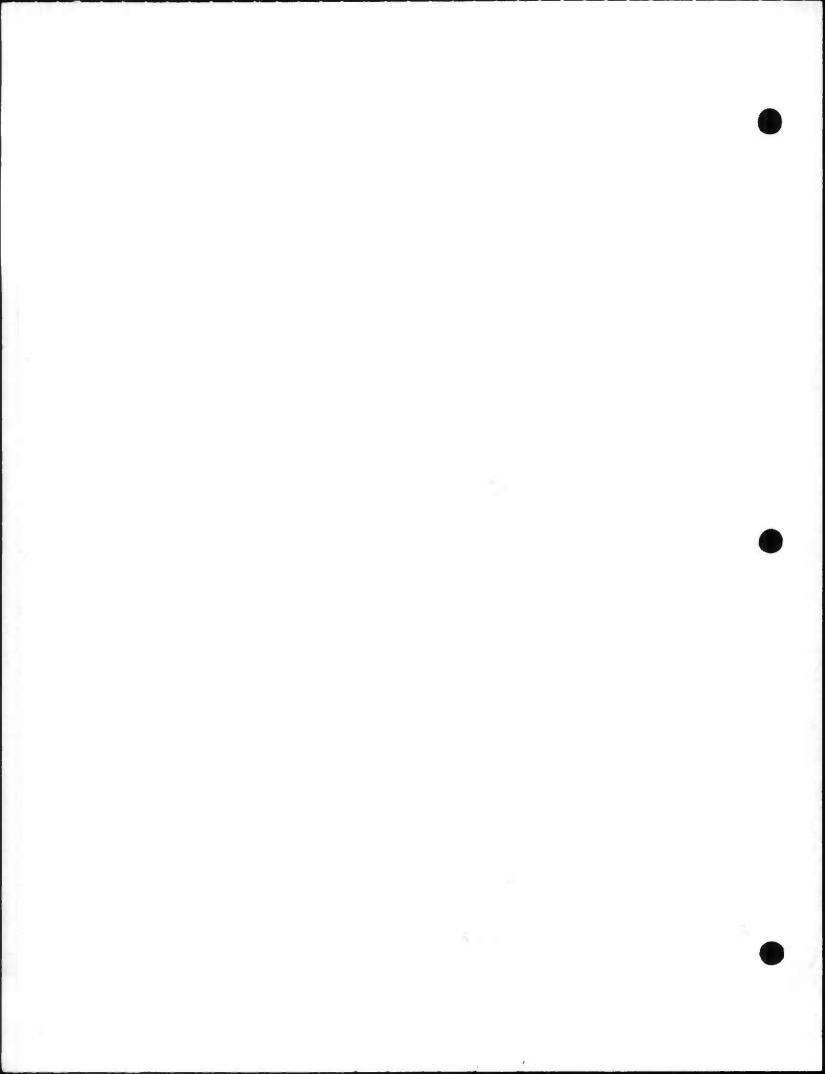
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GHILADI, MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

w

32 BEGISTRAR'S



YEAR

1991

9c. COUNTY OF DEATH

NEW YORK

BALTIMORE

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

EDUCATION

29c. LICENSE NUMBER

047020

1896

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

WHITE

Approximata

interval Betw Onset and Death
White fo

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 1 NO

29d. DATE SIGNED (Month, Day, Year)

1 YES 2 X NO

8. BIRTHPLACE (State or Foreign Country)

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m DIVISION OF VITAL RECORDS, P.O.

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it. Pages 1, 2, 3

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) SEPTEMBER C. MARTHA 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 99 1 🗌 M 2 📈 F 213-74-0175 APR 29, Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR CHARLESTOWN CARE CENTER CATONSVILLE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE CATONSVILLE FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 719 MAIDEN CHOICE LANE, BR328 21228 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marri 1 YES 2 XNO Specify: BY 3. Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INCUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER 4 17. FATHER'S NAME (First, Middle Leat) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ¥ AUSTEN CHURCHILL BE LILLIAN HORTON notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. NANCY KENNY TANGLEWOOD ROAD, CATONSVILLE, MD 21228 9 20a. METHOD OF DISPOSITION
1XC Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 4 Donation 5 Other (Specify) MAPLEWOOD CEMETERY 9-9 BOSTON, NEW YORK 21. SIGNATURE OF PHINERAL SERVICE LICEN xaminer 22. NAME AND ADDRESS OF FACILITY Lully STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD 21228 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final ihe ihe disease or condition resulting in death) breast cauch event. DUE TO (OR AS A CONSEQUENCE OF): traumatic MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? shows any 1 TYES 2 NO PHYSICIAN: S 25. WAS CASE REFERRED TO MEDICAL EeH 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 8 🗆 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 8 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) COMPLETED 8 Could not be 28 4 Homicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 🗌 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner se stated. MPORTANT: 296. SIGNATURE AND TITLE OF CERTIFIER

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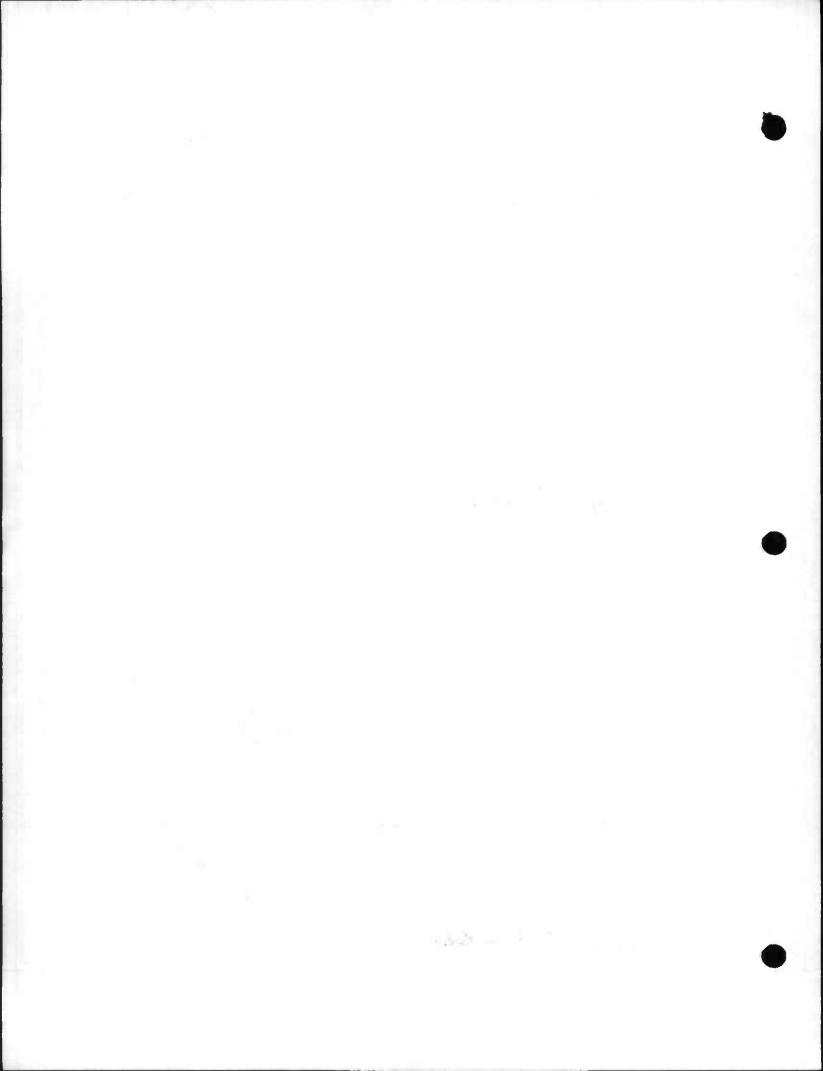
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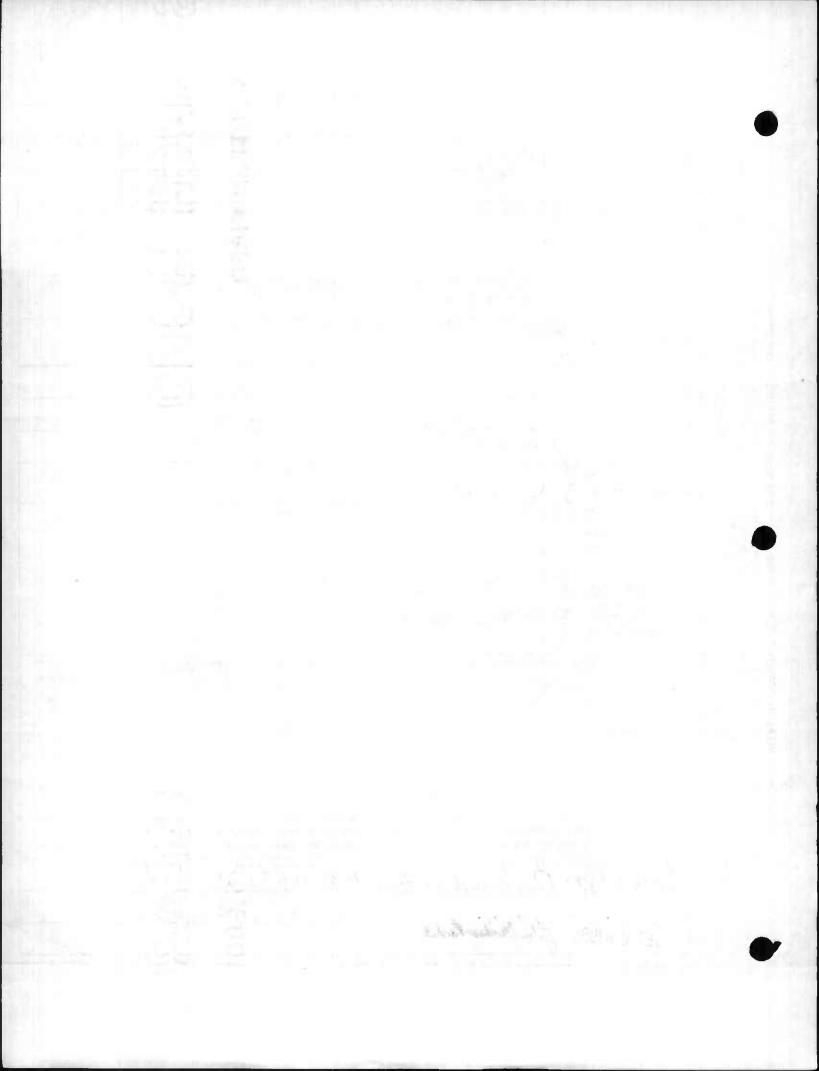
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DORNEY

DHMH-16 Rev 1/89



| | 1. DECEDENT'S NAME (First, Middle, Last, |) | | | TOPTIL | | DEAT | | 2. DAT | REG. NO | J. | | 3. TIME OF DEATH |
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| | Joseph Cohen | | | | | | | | MON | ust 28 | DAY | YEAR | 8:00 A |
| ı | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Is | est birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7 DATE | OF BIRTH | | S. BIRTI | IPLACE (State or Foreign |
| | 165-09-5525 | 1∭M 2 □ F | 88 | YRS. | MONTHS | DAYS | HOURS | serv. | Jul | y 13,1 | 907 | Eng. | |
| | 9a. FACILITY NAME (If not institution, give | | | | | | R LOCATI | | | | _ | NTY OF E | PEATH |
| 1 | 4 Saddlerock Ct | • | | | Silv | er S | Sprir | ng | | | Mc | ontgo | omery |
| | 10e. STATE 10b. COUN | | | 10c. CIT | TY, TOWN C | OR LOCAT | TON | | | | | | 10d. INSIDE CITY |
| 111- | | De. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT | | | | | | | | | LIMITS? | | |
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| - | 11. MARITAL STATUS | 12. WAS DECEDEN | AT EVED IN II C A | DMED | 142 | | 20902 | | NIC 0810 | 140 00 14 W | | S.A. | |
| - 13 | 1 Never Married 2 Merried \$\times Widowed 4 Divorced | VES 2 X | NO | | If yes, sp | ecify Cuba 2 2 NO | n, Mexica | en, Puerto | IN? (Specify Ye Rican, etc.) | es or No- | 14. RACI Blac Spec | E — American Indian, k, White, atc. White white | |
| 1 | 15. DECEDENT'S ED (Specify only highest grad | | 16e. D | ECEDENT'S | USUAL OF | CCUPATIO | ON at of worldr | M7 | 16 | b. KIND OF BU | JSINESS/INI | DUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Give kind of fe. Do NOT u | | | | 8 | | | 377 | | |
| 1 | 17. FATHER'S NAME (First, Middle, Lest) | | CI | othir | ng wo | rker | | | | lothin | | lustr | У |
| | Morris Cohen | | | | | | 1000 | | imme: | Middle, Maidei | n Sumame) | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADDRESS | S (Street a | | | | nber, City or To | wn, State, Zie | p Code) | |
| | David Cohen | | | | | | | | | ngton, | | | 12 |
| F | 20a, METHOD OF DISPOSITION | movel from State | 20h PLACE | ANDDATE | OF DISPOS | ITION /No | me of | | DA | TE 20c 16 | OCATION | City or To | nun Otala |
| 1 | 4 Donation 5 Other (Spenty) | | Mt. I | ebanc | on Ce | mete | ery A | ugus | st 30 | 1995 | Ade1 | phi, | MD |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE L | CENTREE | | | 22. | NAME AN | O ADDRE | SS OF FA | I | ves - | Pears | on F | un'1 Home: |
| + | Je come | Wen | Som | | 47 | 2 N. | _ Was | hine | aton | St. F | alls | Chur | ch, VA2204 |
| | shock, or heart failure. List only one cause on each line. MMEDIATE CAUSE (Final disease or sondition and cause on each line.) | | | | | | | | | | | | Approximate |
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

1 -

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| _ | | | | | | | | | | | | | _ | | | | |
|---------------|-----------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------|--------------------|----------------------------|------------|--------------|------------|-------------------------------------------------------------|----------------------------|---------------------|--------------|---------------------------------------------------------------|-----------|---------------------------------|--|--|
| | | DECEDENT'S NAME (First, Middle, Lest) CHARLES G. CARNAGGIO | | | | | | | | | | | 2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH SEPT. 5. 1995 1712 | | | | |
| | | | | | | | | | | SEPT. | | , | 1995 | | 12 | | |
| | 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 6. AGE (in yrs. la | | IF UNDER | DAYS | HOURS | MIN. | 7. DATE OF I (Month, De | w Weerl | | Country) | | itete or Foreign | | |
| | 212-14-8252 | | 1 💢 M 2 🗌 F | 73 | YRS. | | | | | NOV.2 | 3,19 | | | | CAROLINA | | |
| m | 90. FACILITY NAME (If not in | | | | - 1 | | | | ON OF DE | ATH | | | NTY OF DEA | | | | |
| P | ST. AGNES | | AL | | | | BALT | TMOF | RE | | | BAL | TIMOR | MORE CITY | | | |
| DIRECTOR | 10e. STATE | tob. COUNTY | 7 | | 10c. CITY | r, TOWN | OR LOCAT | ION | | | | | 1 | IOd. INS | IDE CITY | | |
| 100 | MARYLAND | BAI | LTIMORE (| CITY | BALTIMORE | | | | | | | | S 2 NO | | | | |
| A | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | | | 10g. CITIZEN OF WHA | | | | | JNTRY? \ | | |
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| 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. AI | RMED | | | | | IIC ORIGIN? (S | | or No- | 14. RACE - Black. | - Amer | ican Indien, | | |
| BY | 1 Never Merried 2 2 3 Widowed 4 Dive | - | IF YES, OIVE V | MAR OR DATES | | | | | Specify | | ,, | | Specify | W | HITE | | |
| | | CEDENT'S EDU | CATION | WW II | ECEDENT'S | LISUAL C | CCUDATI | 201 | | 165 VII | ID OF BUS | INESS/IN | DUETRY | | | | |
| COMPLETED | (Specify on | ly highest grade | completed) | ((| Give kind of ve. Do NOT us | vork done | during mo | st of work | ing | 100, 101 | 10 OF 803 | 111633/114 | DOSTRI | | | | |
| PLE | Elementary/Secondary (8TH GRADE | 0-12) | College (1-4 or 5 | | NSPEC | TOR | | | | | AUTO |) MAI | NUFAC | TURI | E. | | |
| ∑ | 17. FATHER'S NAME (First, A | Aiddle, Last) | | | | | | 16. MOT | HER'S NA | ME (First, Midd | | | | | | | |
| O | CHARLES CAR | RNAGGIO |) | | | | | D: | ELLA | PRATT | | | | | | | |
| BE | 190, INFORMANT'S NAME (| Type/Print) | | 19 | Db. MAILING | ADDRES | S (Street a | ind Numbe | or Aurei I | Route Number, | City or Town | n, Steta, Zi | p Code) | | | | |
| 9 | CAMILLA CAR | RNAGGIO |) | | 3025 | MARI | DEL A | AVEN | UE - | BALTI | MORE | , MD | 212 | 230 | | | |
| | 20e. METHOD OF DISPOSIT | | oval from State | 20b. PLACE | AND DATE | OF DISPO | SITION | ame of | | OATE | 20c. LO | CATION — | City or Tow | n, State | | | |
| | 4 Donation 5 D Othe | r (Specify) | manager and a second | LOUD | ON PA | | | | | 9/8 BALTIMORE | | | | | | | |
| | 21. SIGNATURE DE FUNER | 21. SIGNATURE OF FUNERAL SERVICE TICEMEE | | | | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. | | | | | | | | |
| | Hours | à () | Dmi S | 11/ | | | | | | AVENUE | | | RE. M | D | 21229 | | |
| | 23. PART I. Enter the c | diseasea, Or | complications the | | | not ente | r the mo | de of dy | /ing, auc | h ae cardiac | or reapi | ratory a | reat, | | pproximate terval Between | | |
| | IMMEDIATE CAUSE (FI | | | | | | | | | | | | | | neet and Death | | |
| | disease or condition CORONARY ARTERY DISEASE | | | | | | | | | | | 3 | YRS | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | |
| Z I | Sequentially list conditions, ATHERO SCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | YRS | | | |
| ATIC | If any, leading to imme cause. Enter UNDERLY | ediate | | NIC OBS | | • | DIITM | ONT A D | 37 D.T | OF A OF | | | | 10 | WDO | | |
| CERTIFICATION | CAUSE (Disease or inj | | G | OR AS A CONSI | | | PULM | UNAK | דת גי | SEASE | | | | 10 | YRS | | |
| H | resulting in death) LAS | ST | | | | , | | | | | | | | | | | |
| CE | | | a | | | | | | | | | | | + | | | |
| AL | PART II. Other algnific | | _ | | resulting | In the u | nderlyin | g cause | given in | Part I. 24 | e. WAS AN PERFOR | | | AVAILAB | UTOPSY FINDINGS ILE PRIOR TO | | |
| EDICAL | | PEPTIC | _ULCER D | LSEASE | | | | | | _ 1 | YES 2 | X NO | | OF DEAT | TION OF CAUSE | | |
| Z | | | | | | | | 7 | | | | | | 1 🗌 YE | S 2 NO | | |
| PHYSICIAN: | DID TOBACCO U | | RIBUTE TO CA | | ATH YE | | | | CERTAI | ן נאַ א | | _ | | | | | |
| CI | EXAMINER? | TO MEDICAL | HOSPITAL: | | | OTHE | R: | | | | | | | | | | |
| HYS | 1 YES 2 NO | | t Cinpetient 2 | | 28b. TIN | | _ | JURY AT | lealdence | 6 Other (S | | NJURY O | CCURED | | | | |
| | /3 | Pending | (Month, i | Day, Year) | IN. | JURY M | | YES 2 | □ NO | | | | | | | | |
| BY | 2' Accident 3 Suicide | Investigation Could not be | 28e. PLACE | OF INJURY — At I | nome, ferm, | street, te | ctory, offic | :0 | | | | | er or Rural Ro | oute Nun | nber, | | |
| TEL | 4 Nomicide | determined | bullding | , etc. (Specify) | | | | | | City or | lown, State) | | | | - 23 | | |
| COMPLETED | 29e. CERTIFIER | TIFYINO PNYS | SICIAN: To the best o | t my knowledge. | death occurr | ed at the | time, date | and plac | e. and due | to the cause | (a) and mai | nner aa st | sted. | | | | |
| ME | anal | | ER: On the besis of | | | | | | | | | | | end me | nner es stated. | | |
| | 29b, SIGNATURE AND TITL | ETOE CERTIFIE | A / A | | | | | 29c. LI | CENSE NU | MBER | | 29d. DA | TE SIGNED | (Month. | Day, Year) | | |
| 8 | | 112 | | - 1 | | | | | 226 | | | | EPT.5 | | | | |
| 5 | 30. NAME AND ADDRESS (| OF PERSON WI | HO COMPLETED CAL | JSE OF OEATH (IT | EM 27) (Type | , Print) | ST. | AGN | | OSPITA | L | | | ,-/ | | | |
| . / | DR. K. VEN | KATARA | M - 900 (| CATON AV | /ENUE | - B | | | | | | 29 | | | | | |
| 1 | 31. DATE FILED (Month, Day | (, Year) | 32. REGISTR | AR'S SIGNATURE | | | | | | | | | - ii | | | | |
| | SEP 0 819 | 395 3 | fell devote | or larly !! | | | | | | | | | | | | | |
| | | U | | | | | | | | | | | | | DHMH-16 Rev 1/89 | | |

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

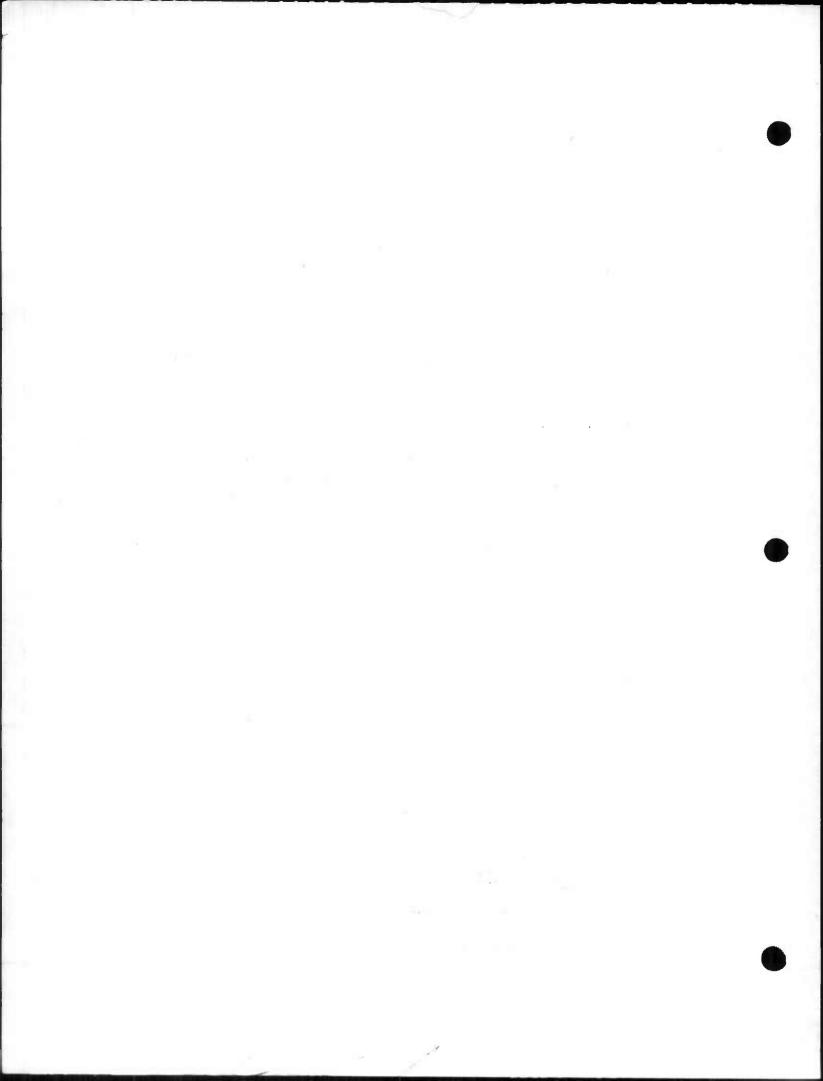
TO THE FUNERAL ORFECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | * REGISTRAR | | | EKIIF | CATE | IL DE | AIFI | F | REG. NO. | | | | |
|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|-----------------|-------------------------------------|-------------------------------------|---------------------|-------------------------------|--------------------------------------------------------|--|
| ė. | 1. OECEDENT'S NAME (First, Middle, Last) Gertrude Ellen | | | Cr | ivell | i | | 2. DATE OF MONTH Augu | DAY | 1 19 | 995 | 3. TIME OF DEATH 6:58 Pm | |
| | 4. SOCIAL SECURITY NUMBER 213-62-4252 | 5. SEX 1 | 6. AGE (In yrs.) | last birthday) YRS. | IF UNDER 1 YE | AR IF UN | DER 24 HRS. | 7. DATE OF (Month, Di AUG . 2 | mr. Year) |)6 | 8. BIRTHE Country, MARY | | |
| | 9e. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TO | WN OR LOC | ATION OF DE | | | | | | |
| 5 | MEMORIAL HOSPITA | Ĺ | | | EAS | CON | | | | TALBOT | | | |
| | 10e. STATE 10b. COUNT | γ | | 10c. CIT | c. CITY, TOWN OR LOCATION | | | | | 10d, INSIDE LIMITS? | | | |
| 5 | | ALBOT | | EA | STON | | | | | 1 - YES 2 X NO | | | |
| 1 | 8 BAKER STREET () | IVDE DADE | \ | | | 10f. ZIP C | 601 | | | HAT COUNTRY? | | | |
| CINE | 11. MARITAL STATUS | 12. WAS DECEDEN | | ARMED | 13. WAS | | | NIC ORIGIN? (S | Specify Yes | | S.A. | American Indian, | |
| 10 | 1 Never Married 2 Merried 3 M Widowed 4 Divorced | Хио | It ye | s, specify C | | n, Puerto Rica | | | Specify | White, etc. | | | |
| מ | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. | DECEDENT'S | USUAL OCCU | PATION or most of we | orkina | 16b. KI | ND OF BUS | INESS/INC | USTRY | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5 + |) | life. Do NOT us | se retired.) | | | | HOMEN | (A 12 T N | T.C. | | |
| | 10TH GRADE 17. FATHER'S NAME (First, Middle, Last) | | - 1 ' | HOMEMA | KEK | 16. M | IOTHED'S NA | ME (First, Mide | HOMEM | | - | | |
| ויי | ELMER ELLSWORTH | WAIN | | | | 144. ** | | NKNOWN | | Surramey | | | |
| DE | 19e. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS (St | reet end Nun | nber or Rural i | Route Number, | City or Town | , State, Zip | Code) | | |
| - | RAYMOND J. CRIVE | | | 8 BAKE | ER STRI | EET (| HYDE 1 | PARK) | _ | | | | |
| | 20s. METHOD OF DISPOSITION 1 Å Burlel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) | noval from State | | of disposition of the place of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c | | | 9/5 | | CATION — City or Town, State FIMORE | | | | |
| 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229 | | | | | | | | | | 1000 | | | |
| \dashv | 27 PART I. Enter the diseases, or | complications the | August the | death Do | | | | | | | | MD 21229 | |
| | ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Suspect | se Dn aach ii | _{ina.} ıptur | e of | | | | | | | Interval Between Onset and Death Months | |
| ALIGN | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | b | (OR AS A CON | SEQUENCE O | F): | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | DUE TO | (OR AS A CON | SEQUENCE O | F): | | | | | | | | |
| 3 | PART ii. Other algnificent conditio | na contributing to | death but no | ot resulting | In the unde | rlying cau | se given in | Part i. 2 | 4a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS | |
| FDICA | ASCVD | | | | | | | | PERFOR | | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MED | | | | | | | | | | | | 1 TYES 2 NO | |
| | DID TOBACCO USE CONT | RIBUTE TO CA | | | | | NCERTAI | NX | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | one) | | | | | | | |
| 2 | 1 TYES 2 NO | 1 Inpetient 2 | | 3 DOA 28b. TJR | | Home 5 C | | 6 Other (S | | M HIBY OC | CUBED | | |
| BY PH | 1 Netural 5 Pending 2 Accident Investigation | (Month, E | | IN. | JURY | WORK? | 2 NO | 28d. DESCR | TIBE HOW I | NJUNT OC | CORED | | |
| - 1 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE C building, | F INJURY — At atc. (Specify) | t home, term, | street, fectory | office | | 261. LOCATI City or | ION (Street e Town, State) | and Numbe | or or Rural R | loute Number, | |
| COMPLETED | Control of the | SICIAN: To the best of e | | | | | | | | | |) end manner es stated. | |
| 岩 | 250. SIGNATUSE AND TITLE OF ENGINE | VIN | 1 | | | | 3525 | | | 29d. DAT | ept. | (Month. Day, Year) 5, 1995 | |
| 2 | Keyin J. O'Ke | efe MD | SE OF DEATH (| Dutch | n, Print) mans | Lane | e Eas | ton,N | 4D 2 | 1601 | | | |
| | St. DATE FILED (Month, Day, Year) | | AR'S SIGNATUR | E | | | | | | | | | |
| | SEP 0 81995 | Jelli altude | arbada | Ц | | | | | | | | | |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 2. & 29d, PER DR. FILM G-727 9/19/95 t.t

| | 1 - FOR STATE OF MARYL REGISTRAR | AND / DEPARTM | ENT OF HEALTH AND | MENTAL HYGIE | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------|----------------|--------------------------------------------------------------------|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) BERNICE DECROSS Dec | Gross | | 2. DATE OF DEATH MONTH | 7,6 199 | | | | | | | | |
| | | 83 YRS. MON | INDER 1 YEAR IF UNDER 24 HR | 7. DATE OF BIRTH | A.F | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| ~ | 9a. FACILITY NAME (If not institution, give street end number) | 9b. | CITY, TOWN OR LOCATION OF | | 9c. COUNTY | | | | | | | | |
| 5 | 5411 Hillen Road | | Baltimore | | N/A | | | | | | | | |
| DIRECTOR | Maryland N/A | | wn or Location timore | | | 10d. INSIDE CITY LIMITS? 1 Y YES 2 NO | | | | | | | |
| | 10e. STREET AND NUMBER | Dai | 101. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | | | | | |
| FUNERAL | 5411 Hillen Road | | 21239 | | U.S | | | | | | | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D. | 2 NO | 13. WAS DECENDENT OF HIS If yes, specify Cuben, Mei 1 YES 2 NO Sp | PANIC ORIGIN? (Specify titlen, Puerto Ricen, etc.) ectly: | | RACE — American Indian, Black, White, etc. Specify: Black | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | 16e. DECEDENT'S USU (Give kind of work of life. Do NOT use reti | lone during most of working | 16b. KIND OF E | USINESS/INDUST | | | | | | | | |
| AP. | 10th - | Laborer | | var | ious t | rades | | | | | | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) Jeremiah Jermiah Jones | | 18. MOTHER'S VIOL | NAME (First, Middle, Meidle a Johnson | en Surname) | 2 | | | | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) Eric DECROSS DeGross | | RESS (Street and Number or Ru | | | | | | | | | | |
| | 200, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State | | | | | | | | | | | | |
| 1 1/2 Suriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE CEMETERY 09-11 BALTIMOR | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Benefit Ben | | | | | | | | | | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raapiratory arreat, shock, or heert failure last only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Dengoration Due to (orals a consequence of): Brain metastases Due to (orals a consequence of): Lung Cancer Due to (orals a consequence of): Due to (orals a consequence of): Due to (orals a consequence of): Due to (orals a consequence of): | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL CI | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 10 11 11 12 14 15 16 17 17 17 18 18 19 19 10 10 10 10 10 10 10 10 | | | | | | | | | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF DEATH (C | heck only one) | | | | | | | | | | |
| IXSI | 1 VES 2 NO 1 Inpettent 2 ER/Out | patient 3 DOA 4 | HER: Nursing Home 5 Residen | | | | | | | | | | |
| | 1 Natural 5 Pending (Month, Day, Year) | 26b. TIME OF INJURY | 26c. INJURY AT WORK? M 1 YES 2 NO | 26d. DESCRIBE HON | W INJURY OCCUR | ED | | | | | | | |
| TED BY | a Control | f — At home, farm, stree | t, tectory, office | 261. LOCATION (Stree City or Town, Sta | | lural Route Number, | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of exemination | | | | | use(e) end manner se stated. | | | | | | | |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c, LICENSE | NUMBER | | GNED (Month, Day, Year) | | | | | | | |
| 10 B | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE |) · | L51 | 24 | Auc | uct 8, 1995 | | | | | | | |
| - | Sonye Danoff, M.D | . Joh | ns Hopkin | is Hosp | ital | | | | | | | | |
| | SEP 08 1995 | MINTURE Randall | | | <i>b.</i> | | | | | | | | |

Approximats Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE

10:15 A.

FOR

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| | REGISTRAR | | | CERTIF | ICATE | E OF | DEATH | | REG. NO | | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------|---------------------------------|----------------|------------------|------------------|-------------|----------------------------------------|---------------|---------------------|----------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | TE OF DEATH | | | 3. TIME OF DEATH | |
| | WENDY | ANNE | DO | MARECK | I | | | Au | g 30, 1 | 995 | YEAR | 10:15 A. | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | lest birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS | 7. DAT | E OF BIRTH | 1 | A. BIRTI | HPLACE (State or Foreign | |
| | 217-62-6450 | 1 🗆 M 2 🔯 F | 42 | YRS. | MONTHS | DAYS | HOURS MIN. | (Mo | onth, Day, Year) | 1053 | Count | ry) | |
| | 9a. FACILITY NAME (If not institution, give | street and number) | 72 | | 9h CITY | TOWN O | R LOCATION OF | _ | in. 13,1 | | | ryland | |
| œ | 1412 Regester A | | | | | | | OEATH | | | 9c. COUNTY OF DEATH | | |
| 5 | RESIDENCE OF DECEDENT | Avenue Loch Hill | | | | | | | | BaT. | tlmo | re County | |
| DIRECTOR | 10a. STATE 10b. COUNT | Υ | | 10c. CI1 | Y, TOWN O | OR LOCATI | ION | | | | | 10d, INSIDE CITY | |
| ā | Maryland Balt | imore County Loch Hill | | | | | | | | | LIMITS? | | |
| AL | 10s. STREET AND NUMBER | | | | | _ | ZIP CODE | | | 10g. CITI | ZEN OF V | WHAT COUNTRY? | |
| ER. | 1412 Regester A | Avenue | | | | | 21239 | | | 1 | JSA | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS OECEDEN | | | 13. 1 | WAS DECE | | PANIC ORIG | SIN? (Specify Yes | | | E — American Indian, | |
| | 1 Never Married 2 Merried | FORCES? 1 | YES 2 | | 1 | If yes, spe | city Cuben, Mex | icen, Puert | | | Bleck | k, White, etc. | |
| BY | 3 Widowed 4 Divorced | | an on onico | Ι. | 1 TYES | X NO Spe | icny. | | | Spec | " White | | |
| 8 | 15. OECEDENT'S EDU (Specify only highest grade | ICATION COMPOSITION | 18a. | DECEDENT'S | USUAL OC | CCUPATIO | N | 1 | 6b. KINO OF BUS | SINESS/IND | USTRY | | |
| Щ | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | (Give kind of life. Do NOT u | se retired.) | ouning mos | t or wonting | | | | | | |
| P | | 3 yrs | . A | Actres | s, Mu | usic: | ian | | Perfor | ming | Art | S | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S | NAME (First | t, Middle, Meiden | den Sumame) | | | |
| BE (| Stephen | | Doma | arecki | | - | Sheil | a Jea | an Pars | | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | AODRESS | Street en | nd Number or Rur | al Route Nu | imber, City or Tow | n, State, Zip | Code) | - | |
| 2 | Mrs. Sheila J. Domarecki 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Regester Avenue, Baltimore, Maryland 21. | | | | | | | | | | | | |
| - 8 | 20a. METHOD OF DISPOSITION | | 20b. PLA | CE ANO DATE | OF DISPOSI | ITION (Nar | ne of | - 1 | | CATION — | | | |
| - 8 | 1 Surisi 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | loval from State | - Gre | en Mou | int C | rema | torv | 9 | /1 Bal | t.imoi | re. | Maryland | |
| - 8 | 21. SIGNATURE OF FUNERAL SEPTEMBER | CANSEE | | | 22.1 | NAME AN | D ADDRESS OF | FACILITY | | | | and y Larie | |
| - " | Martin D. | awson | | | | | | | ld Home | | | | |
| | | | | | | | | | | | | | |
| | 23 PART I Fries the diseases or complications that assessed the death December 1 | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | Onset and Des | |
| | resulting in death) | | | a of Colon with Metastasis | | | | | | | | | |
| - 4 | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 8 | Sequentially list conditions, | b | | A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | (OR AS A CON | A CONSEDUENCE OF): | | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | C. DUE TO | OR AS A COM | SECUENCE O | | | | | | | | | |
| E | that initiated avents resulting in death) LAST | 002 10 | (OIT NO IN COIN. | PR AS A CONSEQUENCE OF): | | | | | | | | | |
| 9 | d | | | | | | | | | | | | |
| | PART II. Other significant condition | ns contributing to | deeth but no | ot reaulting | In the un- | derlying | cause given | in Part I. | 24a. WAS AN | | 24b | . WERE AUTOPSY FINDING | |
| DICAL | | | | | | | | | PERFOR | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| MED | | | | | | | | | 1 1 165 2 | M MO | | OF DEATH? | |
| | DID TOBACCO USE CONT | PIRLITE TO CA | LISE OF DE | EATH VI | ES \square A | ио П | LINICEDTA | JNI 🗖 | | | | 1 YES 2 NO | |
| A A | 25. WAS CASE REFERRED TO MEDICAL | I CA | | LACE OF DEA | | | UNCERIA | MIA [] | | | | | |
| 2 | EXAMINER? 1 Tes 2 No | HOSPITAL: | | | OTHER | 2: | V | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 1 Inpatient 2 I | | 28b. TIM | | | 5 N Residenc | 7 | | | | | |
| | 1 🕅 Natural 5 🗌 Pending | (Month, D | | IN. | JURY | 28c, INJU WOR | RK7 | 28d. D | ESCRIBE HOW II | AJURY OCC | URED | | |
| à | 2 Accident Investigation | 200 DI ACE O | E IN HIRM AA | | | | ES 2 NO | | | | | | |
| | 3 Suicide S Could not be 4 Homicide detarmined | building, | F INJURY — At stc. (Specify) | nome, rarm, | street, tacto | ory, offica | | 28f. LC | CATION (Street e ty or Town, State) | nd Number | or Runal F | loute Number, | |
| | | | | | | | | | | | | | |
| COMPLET | (Check only 1 (A CENTIFTING PHYS | | | | | | | | | | | | |
| ō | 2 MEDICAL EXAMINE | R: On the beele of er | remination end/ | or investigation | on, in my op | pinion, de | ath occured at t | he time, da | te end place, an | d due to the | cause(e |) end manner ee stated. | |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | | | 1 | | | 29c. LICENSE N | | | | | | |
| 38 0 | Henri T. Vo | antas | (lu. | D. | | | 0/100 | | | | 1995 | | |
| | | | | | | | | | | - | | / / | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

29d. DATE SIGNED (Month, Day, Year) 9-8-1995

voontad 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Henri T. Voorstad M.D. 7600 Osler Drive, Suite 209, Towson, Maryland 21204 32. REGISTRAR'S SIGNATURE

SEP 0 81995

0

Stude

DHMH-18 Rev 1/89

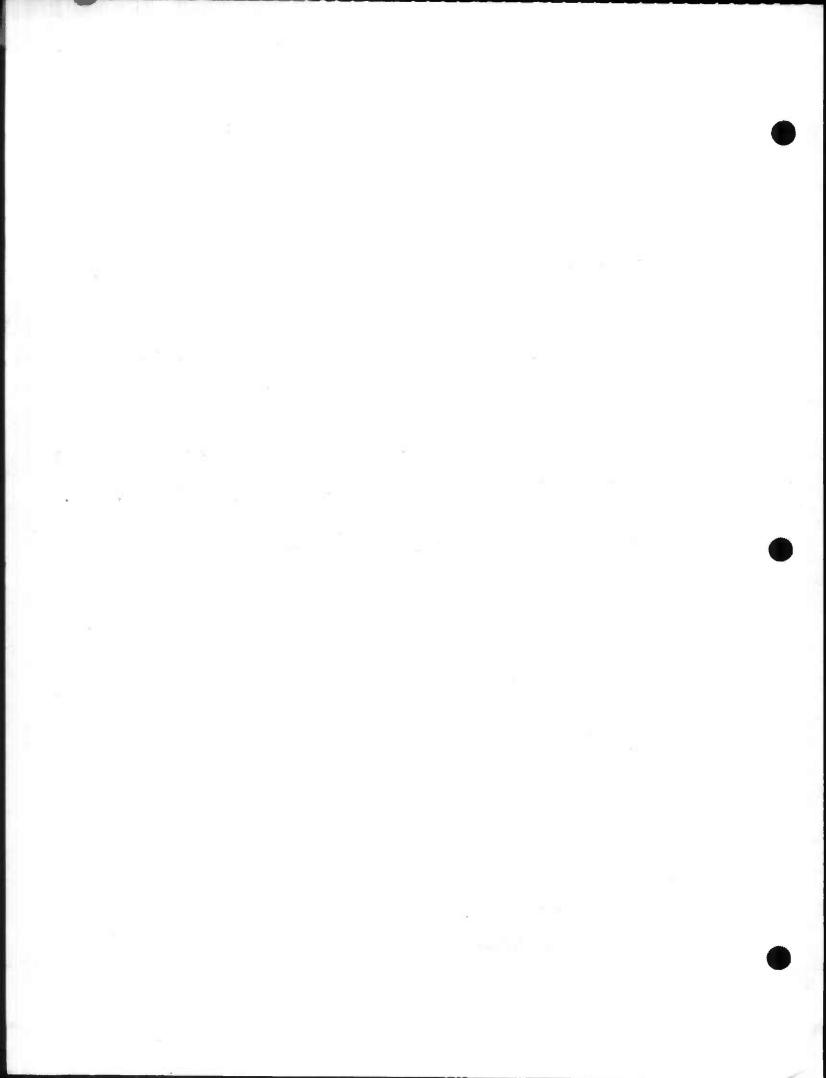
FOR STATE REGISTRAR

1 -

| RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. | sd, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 6876 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be exe | TO THE FLINERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Heath and Memal Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other trauma |

| ē. | DOROTHY E, DIN | KEL | | | SEPTE | MBER 6 | YEAR S | 1115 AM | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------|-------------------------------------------------------------------|----------------------------|------------------------------------|--------------------------------------|--------------------------------------------|--|--|--|
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. le | MON | MOER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF B | HRTN | 8. BIRTNPL. Country) | ACE (State or Foreign | | | |
| | 217-40-0026 1 M 2X F 82 | YRS. | | | | 8,1913 | OHIC | | | | |
| DIRECTOR | ST. AGNES HOSPITAL | | BALTIN | | | | BALTIMORE CITY | | | | |
| EG | 10a. STATE 10b. COUNTY | 10c. CITY, TO | WN OR LOC | ATION | | | 10d, INSIDE CITY LIMITS? | | | | |
| | MARYLAND BALTIMORE 100. STREET AND NUMBER | | CATONSVILLE | | | | LIMITS? 1 VES 2 XNO | | | | |
| BA | 1704 SEMINOLE COURT | | - 1 | 21228 | U.S.A. | | | AI COUNTAIT | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 T IF YES, GIVE WAR OR DATES | | If yes, a | ECENDENT OF NISPANI pecify Cuban, Maxican, is 2 NO Specify: | | pecify Yes or No- | 14. RACE | - American Indian, White, atc. WHITE | | | |
| | (Specify only highest grade completed) (| ECEOENT'S USU Give kind of work | done during n | TION nost of working | 16b. KIN | D OF BUSINESS/IN | DUSTRY | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | fe. Do NOT use ret EACHER | lred.) | | NEW | JERSEY | SCHOOL | SYSTEM | | | |
| ш | 17. FATHER'S NAME (First, Middle, Last) GUY SHUMAKER | | | 18. MOTHER'S NAM | BAUE | | | | | | |
| TO B | | | | ROAD - FRE | | | | | | | |
| | | E AND DATE OF DI | | | OATE | 20c. LOCATION — | City or Town | ı, Stata | | | |
| | 4 Donation 5 Other (Specify) LOUD(| N PARK | | CERY AND ADDRESS OF FAC | 9/9 | BALTIM | ORE | | | | |
| | 199 | > | HUBBA | ARD FUNERA | L HOM | | | 01000 | | | |
| | 23. PART I. Enter the diseases, or complications that caused the o | | | WILKENS A | | | | Approximats | | | |
| | shock, or heart failure. List only one cause on each lift IMMEDIATE CAUSE (Final disease or condition resulting in death) a. | | lee | l Aufo | netie | in | | Interval Between Onset and Death | | | |
| | disease or condition disease or condition a. Ocute Myocardsel Surfaceton 10 hrs. Due to (or as a conseduence of): | | | | | | | | | | |
| ON | Sequentially flat conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| SAT | CAUSE (Disease or Injury | C | | | | | | | | | |
| CERTIFICATION | that initiated eventa DUE TO (OR AS A CONS reaulting in desth) LAST | EOUENCE OF): | | | | | | | | | |
| CE | d | | | | | | | | | | |
| SAL | PART II. Other algnificant conditions contributing to death but not | reaulting in the | ne underly | ing cause given in F | PERFORMED? | | MAILABLE PRIOR TO OMPLETION OF CAUSE | | | | |
| MEDICAL | 0 | | | | - 11 | YES 2 HO | 0 | YES 2 NO | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE | ATH YES | □ NO I | UNCERTAIN | | | | | | | |
| PHYSICIAN | | ACE OF DEATH (| heck only on | | | | | | | | |
| YSI | 1 ☐ YES 2 ☐ NO 1 ☐ Inpetient 2 ☐ ER/Outpetient | 3 🗆 DOA 4 [| | ome 5 🗆 Rasidence (| | | | | | | |
| ВУ РН | 27. MANNER OS-DEATN 1 Netural 5 Pending 2 Accident Investigation | 286. TIME OF | V | NJURY AT VORK? YES 2 NO | 28d. DESCRI | BE HOW INJURY OF | CCURED | | | | |
| COMPLETED | 3 Suicide 8 Could not be 4 Nomicide 8 Could not be detarmined | home, farm, atree | t, factory, of | fica | 281. LOCATIO City or To | N (Street and Number wn, State) | er or Rural Rou | ute Number, | | | |
| PLE | 29a. CERTIFIER (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch | death occurred a | The Ilme, de | ita end place, and due t | to the cause(s |) and manner as st | nted. | | | | |
| OM | one) 2 MEDICAL EXAMINER: On the beels of examination and/o | or investigation, is | my opinion | , death occured at the t | lime, data and | placa, and due to | the cause(s) s | and menner as stated. | | | |
| 96 | 29b. SIGNATURE AND TITLE OF CERTIFIER | U | | DA35 P | BER | 29d. DA | TE SIGNED (A | Aonth, Day, Year) | | | |
| 2 | DR. STEPHEN J. PLANTHOLT - 3449 | | | NUE - SUIT | E #20 | 7 BALTIM | ORE. M | D 21229 | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 0 81995 SEP 0 81995 | | | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

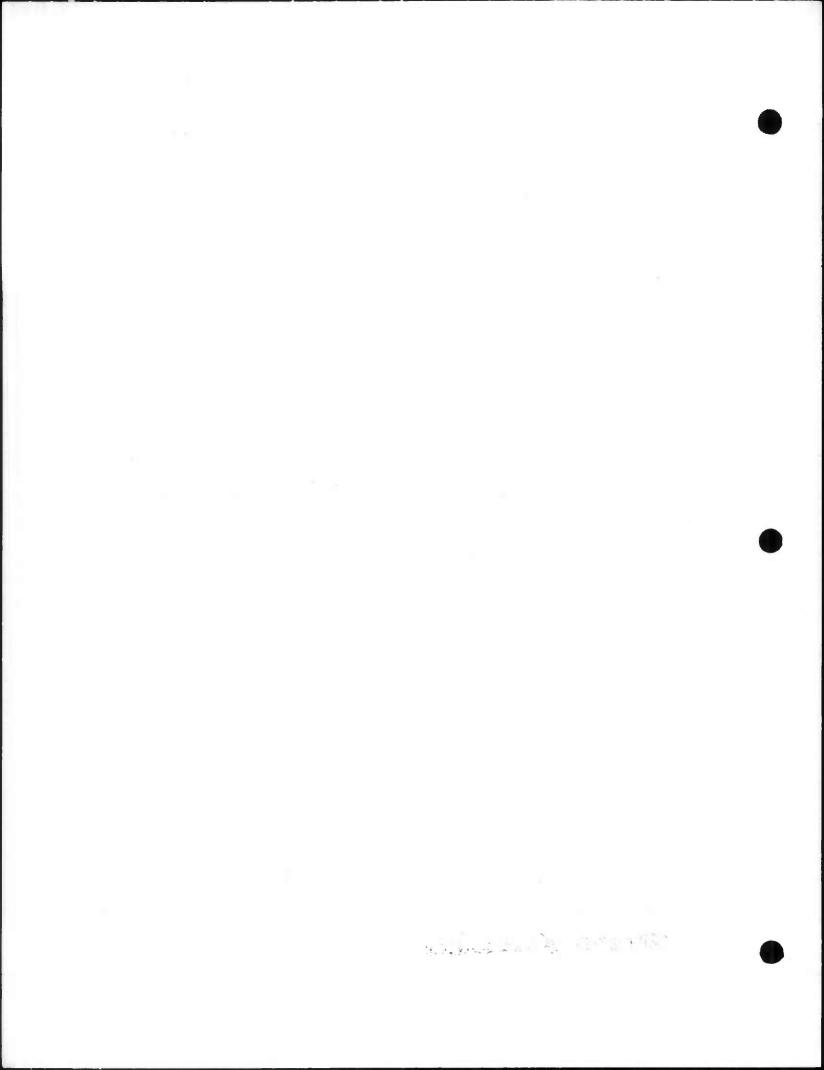


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| DIVISION OF VITAL RECORDS, P.O. BOA 86/60 | DR / | J. J. |
| J | A | 7 |
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| | 뿔 | #1 |
| | TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained | TO THE FINERAL DIRECTOR: After this certificate has been signed by the attendion physician and completely filled to by the funeral diseases again to show |
| | - | _ |
| 1 | 1 | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF GEATH YEAR Deborah Dinisio SEPT 1995 9:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS BRIN. 1 🗆 M 2 🕟 F 215-64-6798 YRS. 43 JULY 12 Washington D.C. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 10337 Lombardi Dr. Ellicott City Howard 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Howard Ellicott City 1 YES 2 NO permit FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10337 Lombardi Dr. burial-transit 21042 USA affending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 XMarried 1 TES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced use as the white ED 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY the hospital or ᆸ be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 12 N/A Homemaker Own Home notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jack J. Davis Beverly Souder 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dinisio Christopher W. 10337 Lombardi Dr. Ellicott City, Md. 21042 pe 20e. METHOD OF DISPOSITION
1 Disposition 2 Chaptage 3 Disposition 3 Disposition 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 9/₄ 20c. LOCATION - City or Town, State must The Green Mount Cemetery Baltimore. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 23, PART I. Enter the diseases/or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory streat, Approximate shock, or heart failure. List only one cause on each line. Interval Between 6 **IMMEDIATE CAUSE (Finel** Onset and Death the cremation. disesse or condition Squamous cell caranoma of tonque 1.545 or other traumatic event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION Sequentisity list conditions, prior to t DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 23 shows any injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE of Health 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) or item State HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA ng Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATN 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE NOW INJURY OCCURED marked, with 1 Netural 44 1 YES 2 NO death BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 00 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be hours after be filed within 72 hours after IMPORTANT: If Item 28 4 Nomicide 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the host of my knowledge, dash occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Barbara al Conley MD D26794 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Univ MD Cancer Ctr 22 S. Greene St Baltimore MD 21201 SEP 0 81995 Statis d'European de M



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

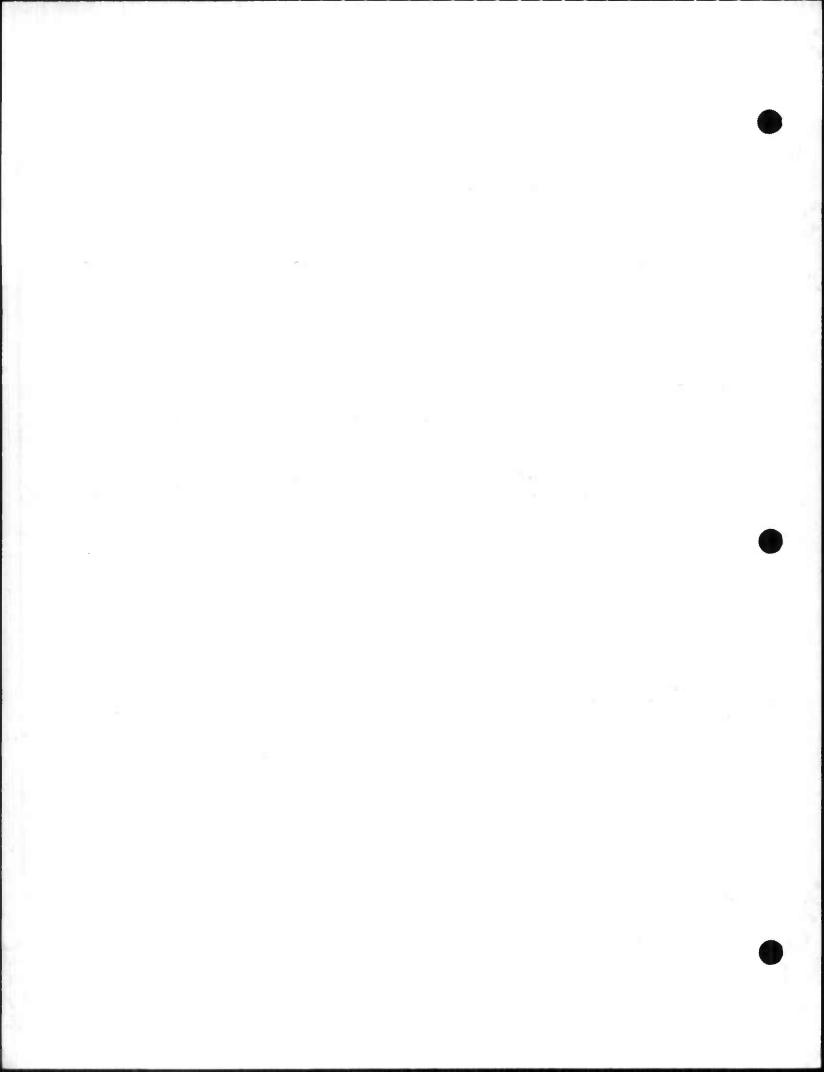
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the the funeral directs, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or minore must be netified at once, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | | EHIL | ICALE OF | DEATH | | REG. | VO. | | |
|---------------|--------------------------------------------------------------|-----------------------|----------------------------------|------------------|-----------------------|----------------------|-----------|----------------------------------------|--------------|-------------------|------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | DATE OF DEATH | | | 3. TIME OF DEATH |
| | Ruth E | lizabeth | n E | DWARI |)S | | Is | month eptembe | r 7.1 | 995 | 1:50 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Is | at birthday) | IF UNDER 1 YEAR | IF UNDER 24 H | - 1 | DATE OF BURTH | | | IPLACE (State or Foreign |
| | 225 03 9655 | 1 🗆 M 2 😾 F | 84 | YRS. | MONTHS DAYS | HOURS M | m. D | (Month, Day, Year ec. 13, | 1010 | Countr | γ) |
| | 9a. FACILITY NAME (If not institution, give a | | 04 | | | | | | - | | h Carolina |
| ~ | | | | | 9b. CITY, TOWN | OR LOCATION (| OF DEATH | | 9c. CO | UNTY OF D | EATH |
| Ö | Franklin Square H | ospital (| Center | | Rossville | | | | Ba | 1timo | re |
| 5 | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | |
| 2 | | | | | | | | 10d. INSIDE CITY LIMITS? | | | |
| 0 | Maryland Baltimore Rosedale | | | | | | | | | | 1 YES 2 X NO |
| 甘 | 10e. STREET AND NUMBER | | | | | | | g. CITIZEN OF WHAT COUNTRY? | | | |
| | 6614 Kenwood Ave | | | | | 2122 | 7 | | | *** | C 3 |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | T F1/F0 11.11.0 | | | 2123 | | | | | .S.A. |
| | 1 Never Merried 2 Merried | FORCES? 1 | YES 2V | NO | If yee, s | pecify Cubers, M | exicen, P | ORIGIN? (Specify uerto Rican, etc.) | Yes or No | 14. RACE Black | - American Indian, , White, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 1 🗆 YE | 3 2 X NO S | pecify: | | | Speck | T.70 - 1 |
| | A SECRETARIO SOL | 777 11 90 | | | | | | | | | White |
| 쁘 | 15. DECEDENT'S EDU- (Specify only highest grade | completed) | 1 (0 | live kind of | USUAL OCCUPAT | ON ost of working | | 16b. KIND OF | BUSINESS/IN | IDUSTRY | |
| 삘 | Elementary/Secondary (0-12) | College (1-4 or 8+ |) "" | . Do NOT u | | | | | | | |
| ₩ | 12 | | | Hou | sewife | | | | Own | Home | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER | S NAME (| First, Middle, Mei | ten Surname) | | |
| BE (| Thomas Ash Hance | ock | | | | Nanc | v P | Lee | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (Street | | | | Town State 7 | (in Code) | |
| 2 | Hebron Edwards, J | | | | | | | | | | 1007 |
| | 20e. METHOD OF DISPOSITION | | | | Kenwood | | alti | | | | |
| | 1 D Buriel 2 Cremation 3 Rem | ovat from State | cemetery co | ameton, or o | OF DISPOSITION (A | | | | LOCATION - | | |
| | 4 🗗 Donation 5 🗆 Other (Specify) | | Garde | ens o | t Faith | | 1/95 | | altimo | re Co | o., Maryland |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENBEE | | | 22. NAME A | ND ADDRESS O | F FACILIT | eral Ho | - D | 70 | |
| | * 1 1 1 - | () | 1 | | | | | | | - | |
| \vdash | 23. PARTA, Enter the diseases, or o | | m | | 1407 | Easter | n Av | e Balt | more, | Mar | yland 21221 |
| | 23. PART I. Enter the diseases, or cahock, or heart fallure. | Last only one ceu | caused the di se on each line | eath. Do r e. | ot enter the m | ode of dying, | auch as | cardlec or re | apiratory a | rreat, | Approximata interval Between |
| | IMMEDIATE CAUSE (Finel | | ~ | | | | | | | | Oneet and Daeth |
| | disease or condition resulting in death) | . (| -UN | | | | | | | | 1 1 days |
| | | DUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | a day |
| z | | h | | | | | | | | | |
| CERTIFICATION | Sequantially list conditions, If any, leading to immediate | OUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | |
| 3 | cause, Enter UNDERLYING | | | | | | | | | | |
| Ē | CAUSE (Disease or Injury that Initiated events | DUE TO | OR AS A CONSE | OUENCE OF | F): | | | | | | |
| F | resulting in death) LAST | | | | | | | | | | 1 |
| 빙 | | 0 | | | | | | | | | |
| | PART II. Other algnificant condition | a contributing to | deeth but not i | reaulting | n the underlyir | g cause give | n in Pari | 1, 24s, WAS | AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | | ORMED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| 입 | | | | | | | | 1 L YES | 2 NO | | OF DEATH? |
| Σ | DID TODA COO LIST CO. IT | | | | | | | _ | | | 1 YES 2 NO |
| Z | DID TOBACCO USE CONTI | RIBUTE TO CAL | | | | | TAIN [| | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | E OF DEAT | H (Check only one | | | | | | |
| S | 1 TYES 2 THO | 15 Inpatient 2 🗆 | ER/Outpatient 3 | □ DOA | OTHER: 4 Nursing Hor | ne 5 🗆 Resider | nce 6 🗆 | Other (Specify) | | | |
| ξI | 27. MANNER OF DEATH | 28e. DATE OF | | 28b. TIM | | JURY AT | 280 | I. DESCRIBE HO | W INJURY O | CURED | |
| | 1. Natural 5 Pending | (Month, Da | y, rear) | INJ | | ORK? YES 2 NO | | | | | |
| ВУ | 9 Sulaida | 28e. PLACE OF | INJURY At ho | me, term, a | street, tectory, affi | 10 | 281 | LOCATION (Stre | at and Numbe | er or Rumi B | nute Number |
| | 4 Homicide 8 Could not be determined | building, a | ite. (Specify) | | | | | City or Town, St | ete) | | outs Humber, |
| Щ | 29e. CERTIFIER | | | | | | | | | | |
| 릴 | (Check only | CIAN: To the beat of | | | | | | | | | |
| COMPLET | 2 MEDICAL EXAMINE | R: On the basie of ex | amination end/or | Investigatio | n, in my opinion, | leath occured at | the time | , date end place, | end due to t | the couse(s) | end menner es stated. |
| S I | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | 29c. LICENSE | NUMBER | | 294 04 | TE GIGNED | (Month, Day, Year) |
| 00 | PMAIL | 11/1 IN | 2 | | | | 150 | 598 | Zad. DA | 910 | CX T |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | D COMPLETED CAUS | E OF DEATH ATE | M 27) /3- | Orient | | 10- | 10 | | 110 | [7] |
| | Andreas | AA . | ST DEATH (ITE | | | Ali | 1/ | 212- | 1 | 1 1 | |
| | , vilines, | 1110 | 709 | 140 | itin | 12110 | 1/0 | 1102 | <u> </u> | | |
| | 31. DATE FILED (Month, Day, Year) | REOISTRAF | S SIGNATURE | | | | | | | | |
| - 1 | SEP 0 81995 | The war | HAP RANG | A. | | | | | | | |



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPARTM CERTIFIC | MENT OF H | EALTH AND DEATH | MENTAL HYGII | | | | |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------|--------------------|--------------------------------|-------------------------------------------------|------------------------------|-------------------------|---------------------------------------------------------------------------|---------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | YEAR | 3. TIME OF DE | ATN |
| | HAKIN Hakim | | EL-AMIN | | | SEPTEMBE | | 995 | 9:10 | Рм |
| | 219-40-3169 | | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 1940 | Carreta | PLACE (State or | Foreign |
| | 9a. FACILITY NAME (If not institution, give st | | | a. CITY, TOWN O | R LOCATION OF D | | | | | |
| OR | THE JOHNS HOPKIN | NS HOSPITAL | | BALTIMO | RE CITY | | | 9c. COUNTY OF DEATN N/a | | |
| ECT | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | 1 | | OWN OR LOCAT | | / | | | | |
| DIRECTOR | | N/A | | ALTO | ON | | | | 10d. INSIDE CIT LIMITS? 1 X YES 2 | |
| | 10e. BTREET AND NUMBER | N/ A | 1. | | ZIP CODE | | 10g. CITIZ | ZEN OF W | HAT COUNTRY? | |
| FUNERAL | 3318 W. ROGERS | AVE | | | 21215 | 5 | | .s. | | |
| F | 11. MARITAL STATUS 1 Never Married 2 X Married | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS DECI | ENDENT OF NISPAI | NIC ORIGIN? (Specify in, Puerto Rican, etc.) | Yes or No- | 14. RACE | - American Inc. | llen, |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | | 2 NO Specif | | | | BLACK | |
| | 15. DECEDENT'S EDUC | | 16a. DECEDENT'S US | | | 16b. KIND OF I | USINESS/IND | | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 6+) | (Give kind of work life. Do NOT use re | tired.) | | 0.00 | | 31701-1 | | |
| MP | 12TH | 2YRS | MAINTEN | ANCE | WERE DEF | ALL | IED C | HEM | ICAL C | 0. |
| 8 | 17. FATNER'S NAME (First, Middle, Last) | 017 | | | | ME (First, Middle, Maid | | | | |
| B | JAMES B. JOHNS 19a. INFORMANT'S NAME (Type/Print) | ON | | | BESS | | OWN J | | SON | |
| 2 | YEKIHA EL-AMIN | | | | | Route Number, City or T | | | 1.5 | |
| | 20a. METHOD OF DISPOSITION | | b. PLACE AND DATE OF D | | | | LOCATION - C | | | |
| | 1 N Burlet 2 Cremation 3 Remo | ovel from State | TNG MEMO | PRIAL | PK | | NDALL | | |) |
| | 21. SIGNATURE OF FUNERAL BERVICE LIC | ENSEE | | 22. NAME AN | D ADDRESS OF FA | CILITY | | | | |
| | Timo | H. Dhr | MOSM | MAR | CH F/H- | WEST 43 | 00 WA | BAS | H AVE | |
| NO | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, enock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Advanced Bronchoalvcolar Lung CAVCER DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificent conditions | e | | | cause given in | | AN AUTOPSY ORMED? 2 NO | | WERE AUTOPSY I AMPLABLE PRIOF COMPLETION DF OF DEATH? 1 YES 2 | CAUSE |
| Ä | DID TOBACCO USE CONTR | RIBUTE TO CAUSE C | | | UNCERTAIN | VX | | | | |
| ZZ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | | | | | | |
| ž | 27. MANNER OF DEATH | 1 N Inpatient 2 ☐ ER/Out | patient 3 DOA 4 (| | | 8 Other (Specify) 26d. DESCRIBE NOV | V IN HIEV ACC | UDED | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJURY | WOF | | 200. DESCRIBE NOT | INJUNI OCC | UNED | | |
| TED BY | 2 Accident investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spe | / — At home, term, stree | t, factory, office | | 281, LOCATION (Stree City or Town, Sta | et and Number (| or Rural Ro | oute Number, | |
| COMPLETED | | ZIAN: To the best of my know | | | | | | | and manner as | etated. |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LIGENSE NUM | | | | Month, Day, Year | |
| 0 | Othern Ha | udle 1 | 10 | | Nas | 01 | ►5en | temb | c 6. 19 | 95 |
| Ē | Johns Hopkins | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Prin | Volfe 5 | treats Bri | Itimore. | Mary | and | 2128 | フ |
| | SEP 08 1995 | THE OWN DOBLERS | Austall | | | 1 | 1 | 7 11 | 1-31-30 | |

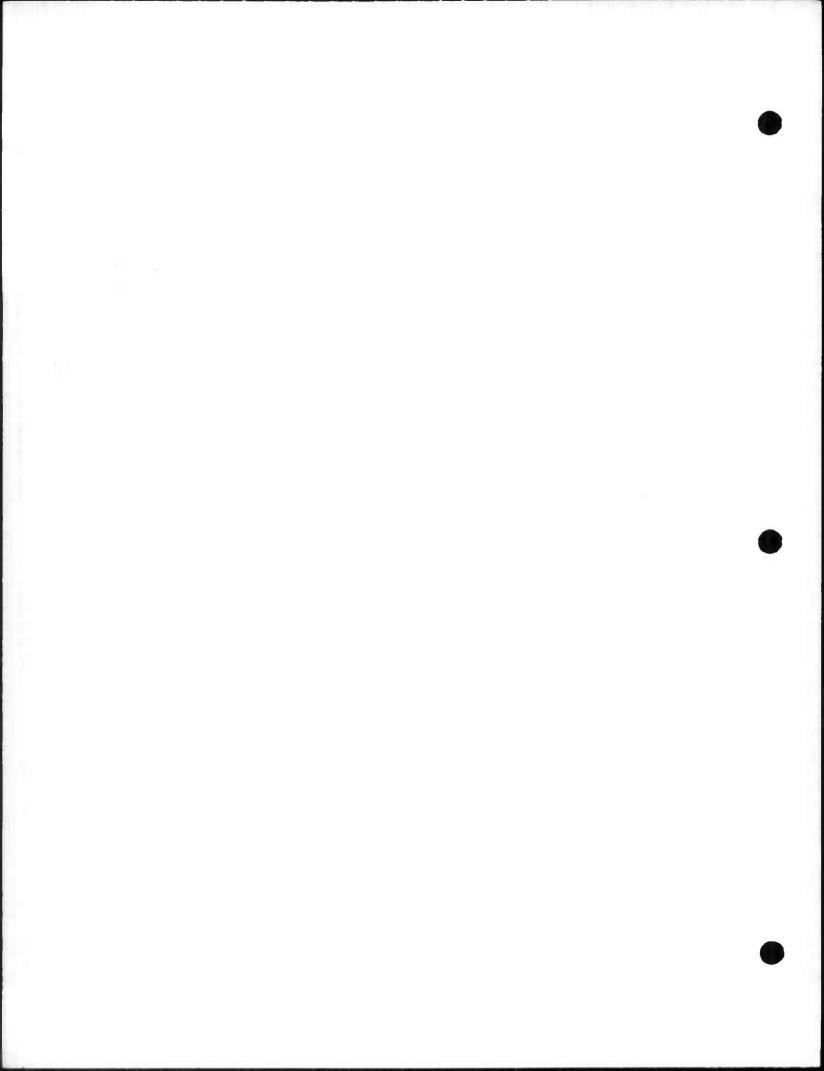
n. Page 6 may be retained by the hospital or attending physician.
oral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| DALLINGOL, MAGILLANI | rest hours after death. Page 6 may be retained by the hosp | by filled in by the funeral director, page 5 should be detached ation, or removal. | the medical examiner must be notified at once. |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|------------------------------------------|-------------------------------------------------------------------|----------------------------|
| 1. DECEDENT'S NAME (First, Middle, Lest) | | 2. DATE OF DEATN |

| | REGISTRAN | | | | CERTI | FICAL | E UF | DEA | IH | F | REG. NO | | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------|-------------------------------|-----------------------------------|---------------|--------------------------|---------------------------------------|-----------|------------------------------------------|-------------------------------|--------------|--------------------------------------|--------------------------------------------------------|
| - 0 | 1. DECEDENT'S NAME (First, Mic HAROLD W. E | | | | | | | | | 2. DATE OF MONTH | D. | | YEAR | 3. TIME OF DEATN |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | R ACE /le u | rs. last birthday | | D A MEAN | | | Aug | 30 | 19 | 95 | 02:42 A M |
| 8 | 218-14-1137 | | 1 📉 M 2 🗆 F | 76 | YRS. | MONTHS | DAYS | HOURS | MIN. | 7. DATE OF 1 (Month, Di MAR . 1 | ny, Year) | 9 | Country | PLACE (State or Foreign V) YLAND |
| E C | So. FACILITY NAME (If not institute HOWARD COUNTY | | | PITAL | | | OLUN | OR LOCATI | ON OF DE | EATN | | | WARD | EATH |
| 5 | RESIDENCE OF DECED | DENT | | | | | | | | | | | | |
| DIRECTOR | MARYLAND | MARYLAND BALTIMORE CITY | | | | | | 10c. CITY, TOWH OR LOCATION BALTIMORE | | | | | 10d. INSIDE CITY LIMITS? 14 YES 2 NO | |
| FUNERAL | 1820 SPENCE S | TREE | Т | | | | 10 | 7. ZIP COD | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 X Mar 3 Widowed 4 Divorced | | 12. WAS DECEDEN FORCES? 1 IF YES, OIVE W | YES 2 | ₽ ₩NO | 13. | If yes, sp | | n, Mexice | NIC ORIGIN? (S in, Puerto Ricad y: | | or No— | 14. RACE Black Speck | — American Indian, , White, atc. |
| 0 | 15. DECEDE | NT'S EDUC | ATION | 16 | e. DECEDENT | S USUAL C | CCUPATION | ON | | 18b, KIN | ND OF BUS | INESS/IND | USTRY | |
| COMPLET | (Specify only hig Elementary/Secondary (0-12) H/S GRAD | | College (1-4 or 5 s | +) | (Give kind o | use retired.) | during mo | oat of worki | ng | | | O SH | | 20 |
| WO | 17. FATNER'S NAME (First, Middle | . Lest) | | | TREBU | JER | | 18 MOT | HED'S NA | | | | LKI | |
| BE C | ETHEL HARMAN | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | 17363 TOWN.PA | | | |
| | 20e, METHOD OF DISPOSITION 1 Denoted 2 Cremetion 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of camelex, cremetion, or other place) 20c. LOCATION — City or Town, State | | | | | | | | | | wn, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE // 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | שאַ | | |
| | Jackie | D. | Skan | mo | ~ | | | | | L HOME | | | E. MI | 21229 |
| - 2 | 23. PARY I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | | Approximate | | |
| | IMMEDIATE CAUSE (Finsi disease or condition | | | | | | | | | | | | | interval Between Onset and Death |
| | resulting in death) | | | | ic Sho | | | | | | | | | 14 hours |
| NO | Sequentially list conditional, | | | | | | | | | 14 hours | | | | |
| E¥ | If sny, leading to immediate cause. Enter UNDERLYING | ٠, | COPI | | OLOGENOL . | Jr J. | | | | | | | | 10 years |
| CERTIFICATION | CAUSE (Disesse or injury that initiated events resulting in death) LAST |) . | - | | NSEQUENCE | OF): | | | | | | | | 10 years |
| L 斯 | resulting in death) EXST | d | l, | | | | | | | | | | | |
| | PART II. Other significent of | conditions | contributing to | death but r | not resulting | in the u | nderlyln | g cause (| given in | Part i. 24e | . WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | Tracheost | omy | | | | | | | | 10 | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Σ | DID TORACCO LISE | CONITR | IDITE TO CA | UCE OF F | SEATH V | rc 🖂 | NO F | 1 11116 | | | | | | 1 - YES 2 NO |
| AN | DID TOBACCO USE 25. WAS CASE REFERRED TO ME | | IBUIE IO CA | | PLACE OF DE | | | JUNC | ERTAIN | 1 1 | | | | |
| SIC | EXAMINER? | | HOSPITAL: | | | OTHE | R: | | ald-aa- | 8 Other (Sp | . W | | | |
| PHYSICIAN: | 27, MANNER OF DEATH 1 📉 Natural 5 🗌 Pend | | 28e. DATE OF (Month, De N/A | INJURY av. Year) | 28b. Ti | ME OF | 28c, INJ | URY AT | | 28d. DESCRIE | | JURY OCC | URED | |
| ED BY | 3 Suicide 8 Coul | itigation id not be rmined | 28e. PLACE O | | At home, term | | | | J NO | 28f. LOCATIO | | nd Number | or Rural Re | oute Number, |
| E | | | | | N/A | | | | | | | N/A | | |
| COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYII DICAL | EXAMINER | CIAN: To the beat of as | my knowledge amination and | e, death occui d/or investigat | on, in my | time, date opinion, d | and place | end due | to the cause(a time, data and |) and man place, and | ner as state | d. cause(a) | and manner ee stated. |
| ш | 29b. SIGNATURE AND TITLE OF | | / | 2/ | 01/ | | | | NSE NUM | | | | | (Month, Day, Year) |
| 0 8 | Rita E. Ki | ing, | M.D. 17 | Ita 8 | Kn | 191 | 10 | _ D37 | 7155 | | | | | 6, 1995 |
| | 30. NAME AND ADDRESS OF PER | | | | | - | ent. | Parku | Jav (| Columb | ia. N | √D 21 | 044 | |
| | SEP 0 8 199 | | 32. REGISTRA | | | | | | , | - Jamo | | | V | |
| | J | - 0 | | | ~ 7 | | | | | | | | | |



hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

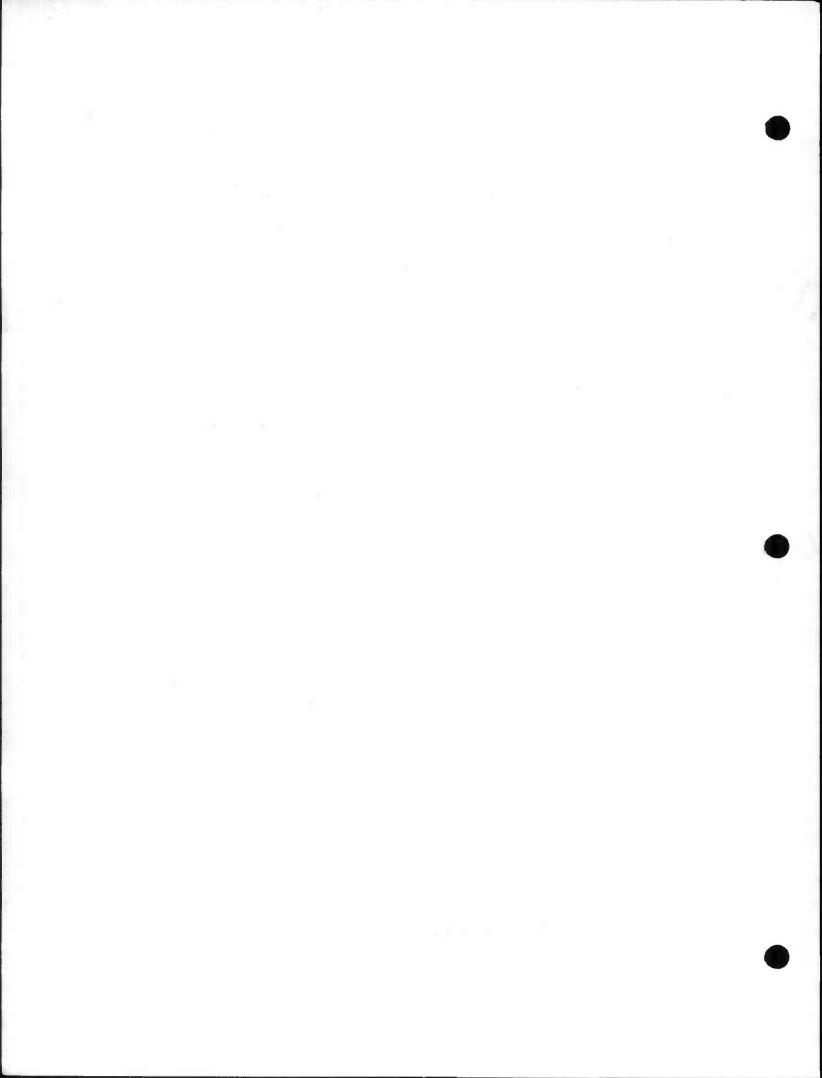
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 6876

| | i | 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | | | | | 2. DATE OF MONTH | OEATH DAY | , | YEAR | 3. TIME OF DEATH |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------|------------------------|-----------------|---------------|-------------------|--------------------|-------------|-------------------------|-------------------|------------------------|------------------|-------------------------------------------|
| | ľ | J01 | HN | FRANK | FALI | LS | | | | | SEPT | | . 19 | | 6:42 A |
| | | 4. SOCIAL SECURITY NUMB | | 5. SEX | 8. AGE (in | yrs. last birth | | INDER 1 YEAR | - | ER 24 HRS. | 7. DATE OF (Month, D | BIRTH | - | | PLACE (State or Foreign |
| Б | | 241-18-613 | 1 | 1 🔀 M 2 🗆 F | | 73 Y | RS. MON | THS DAYS | HOURS | MIN. | APR. | 7,19 | 22 | RE | ÍDSVILLE, NO |
| 3 should | - | 9e. FACILITY NAME (If not in | | | | | 9b. | CITY, TOW | N OR LOCAT | | | | 9c. COU | NTY OF D | EATH |
| 2, 3 | CTOR | AND REAL PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPE | | ANOR NU | RSING | HOME | | | BALT | TIMOR | E CIT | Υ | | n/a | a |
| es 1, | W | 10a. STATE | 10b. COUNTY | 1 | | 100 | . CITY, TO | WN OR LO | CATION | | 10d. INSIDE CIT | | | 10d, INSIDE CITY | |
| . Pag | DIR | MARYLAND | | n/a | | | BALTIMORE | | | | | L104 | | | LIMITS? |
| ermit | 4 | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | | | 10g. CITIZEN OF W | | | 171 |
| insit ; | 8 | 301 | l MC | MEHEN | STREET | T APT | .604 | | 2 | 21217 | | | UNI | ITED | STATES |
| the burial-transit permit. Pages 1, | FUN | 11. MARITAL STATUS | | 12. WAS DECEDER | NT EVER IN L | J.S. ARMED | | | | | NIC ORIGIN? (S | | or No- | 14. RACE | — American Indian, c, White, etc. |
| e pri | ВУ | 1 Never Married 2 3 Widowed 4 X X Divo | | FORCES? IF YES, GIVE | WAR OR DATE | ES | | | ES 2 XX | | | 11, 0101) | | Speci | |
| SS | ED E | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | EOENT'S EDU | CATION | - 1, | 16a. DECEDE | Hell S'TA | | | | 16h KI | ND OF BUS | INCCC (INC | HIETRY | DEACK |
| r use | ETE | (Specify online Elementary/Secondary (Control of the Control of th | y highest grade | completed) College (1-4 or 5 | | (Give kir. | nd of work of | done during | most of worl | king | 100. KI | ND OF 803 | INESS/INL | JUSTRY | |
| ped fo | | 10 th | P-12) | Conege (1-4 or 5 | +1 | MAI | NTEN | ANCE | | | SE | NTOR | CIT | TT7F1 | BUILDING |
| Jetach Dince. | COMPL | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MO | THER'S NA | ME (First, Mide | | | 1221 | DOTEDING |
| 2 to | ш | JOHN F | ALLS | | | _ | | | | | unknow | n | | | |
| 5 should notified | TO B | 19a. INFORMANT'S NAME (7 | | | | 1000000 | | RESS (Street | et and Numb | er or Rural | Route Number, | City or Town | , State, Zip | Code) | |
| age 5 | - | | RIVERS | | , | 23: | 1 WE | EST 1 | 16 TH | ST | ., apt | .10, | NEW | YORK | NY 10026 |
| ector, pa must b | | 20a. METHOD OF DISPOSIT 1 Burlai 2X.XCrematic | on 3 🗆 Rem | oval from State | | ery, cremator | | | (Name of | | DATE | 20c. LO | CATION — | City or To | wn, Stata |
| direct | | 4 Donation 5 Other 21. SIGNATURE OF FUNERA | | SENDER | _ gre | eenmou | unt | | etery | | 9-8 | BAL | TIMO | DRE, | MARYLAND |
| funeral dir examiner | | 1. SIGNATURE OF FOREIX | - SENTICE EN | 111 | 0 | | | | | | | | | | |
| the fur | | Xes | - 1 | ollar | el | | | WM. | C. M | IARCH | FH1 | 101 | E. 1 | NORTH | AVENUE |
| signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Heath and Mental Hygiene prior to burial, cremation, or removal. ws any injury, or other traumatic event, the medical examiner must be notified at once. | | 23. PART I. Enter the d shock, or h | iseesea, or deert fellure. | complications the | at caused t | the death. | Oo not e | enter the | mode of d | ying, auc | h ea cerdiad | or reapi | ratory an | reat, | Approximate Interval Batwee |
| y filled ition, or the m | | IMMEDIATE CAUSE (FIR | nal | 01 - | | . / |) | 0.0 | Pa | . 0 | 0.0 | | | | Onset and Dear |
| ertely ematic | | disease or condition reaulting in death) | \rightarrow | e. Cha | one | 6 6 | | oce | 1-00 | | le . | | | | |
| al, crema event, | | | | | | | | | | | | | | | |
| ician and c nor to burk traumatic | NO I | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF): | | | | | | | | | | - | | | |
| sician infor to traum | ÄT | | | | | | | | | | | į | | | |
| ene p | 直 | CAUSE (Disease or Injuthat initieted eventa | II) | DUE TO | OR AS A C | ONSEQUEN | CE OF): | _ | | | | | | | |
| Hygin or o | ERTI | resulting in death) LAS | T | d | | | | | | | | | | | |
| Menta jury, | 0 | PART II. Other significent conditions contributing to deeth bigt not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDS | | | | | | | | | | | . WERE AUTOPSY FINDING | | |
| ed by the att th and Menta any Injury, | EDICAL | | (200 | maly | A | eter | up | De | 800 | 00 | | PERFOR | MED? | 1 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| signer Health | ED | | PRRI | Miresol | Q V | agei | ita | 1 000 | 200 | 1 | _ ' | YES 2 | XNO | | OF DEATH? |
| t. of Healt shows | I: M | DID TOBACCO U | SE CONT | RIBUTE TO CA | | | _ | □ NO′ | UN | CERTAI | N 🗆 | | | | I TES 2 NO |
| THE FUNERAL DIRECTOR: After this certificate has been filed within 72 hours after death with the State Dept. of PORTANT: If Item 28 is marked, or Item 23 sho | SICIAN: | 25. WAS CASE REFERRED T | | | | B. PLACE OF | | | | | | | | | - |
| State E | SIC | EXAMINER? | | HOSPITAL: | ☐ ER/Outpat | lent 3 🗆 D | OA XX | HER: Nursing H | iome 5 🗌 | Residence | 8 Other (S | ipecify) | | | |
| s certif | РНУ | 27. MANNER OF DEATH | | 28a. DATE O | F INJURY Day, Year) | 288 | . TIME OF | | INJURY AT WORK? | | 28d. DESCR | | NJURY OC | CURED | |
| fer this cath with marked, | ВУ | | Pending investigation | | - ay, roury | | 1100111 | M 1 [| YES 2 | □ NO | | | | | · |
| R: Aft er dea is m | ۵ | 3 Suicide 8 | Could not be | 28a. PLACE building | OF INJURY - | - At home, f | arm, atree | t, lactory, o | ffice | | | ON (Street a | nd Numbe | r or Rurai I | Route Number, |
| rs afte | ETE | 4 Homicide | determined | | | | | | | | | | | | |
| AL DIREC 72 hours 11 Item | | | TIFYING PHYS | ICIAN: To the beet o | of my knowled | dge, death o | ccurred at | the time, d | late end ple | ca, end due | to the cause | (s) and man | ner aa ate | ted. | |
| NERA Thin 7 | COMPL | one) 2 MED | ICAL EXAMINE | R: On the besis of | examination | and/or Invest | tigstion, in | my opinio | n, death occ | ured at the | time, date an | d place, en | d due to th | he cause(s | i) and manner as stated. |
| TO THE FUNERA De filed within 7 IMPORTANT: 1 | BE C | 29b. SIGNATURE AND, TITLE | OF CERTIFIE | | 10 | 1 | | | 29c. LI | CENSE NU | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| To To Ti | TOE | anne | Class | llell | 70 (| | | | 1 8 | 6 P | 18 | | 19 | 18 | 195 |
| | | AN) L | 3ERC | | | | Type, Prin | 1 | 000 | BM | 20 | MI | 21 | 211 | |
| | | SEP 0 819 | | A Felia III | ARE GU | upe. | | | | | | | - 11 | | |
| | | SEF U 013 | 0 | | | | | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



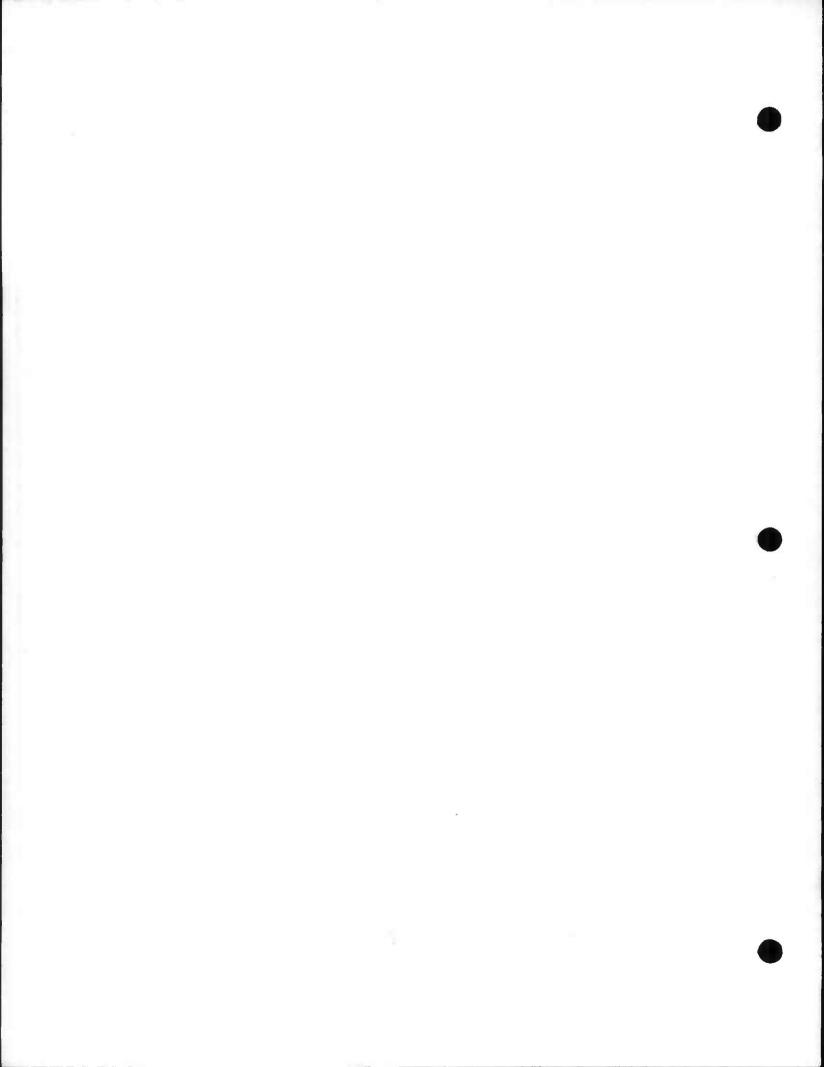
y the hospital or attending physician. He hospital or attending physician. He detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| medical examiner must be notified at once. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| or removal. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, state processing the modified and the state for modified and the former 28 to modified and the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the former state of the fore |
| d in by the funeral director, page 5 should be detached | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached |
| nours after death. Page 6 may be retained by the hosp | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi |
| | |

| STATE OF MARYLAND | | | | | MENTAL | HYGIENE |
|-------------------|------------|----|------|---|--------|----------|
| C | ERTIFICATE | OF | DEAT | Ή | | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | EALTH AND N | MENTAL HYGIENE REG. NO. | | |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Las | 0) | | | V 1 | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | NATHANIEL | FLETCH | ER | | | MONTES DAY | | 12 Pm |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 0. BIRTH | IPLACE (State or Foreign |
| | 216-24-7293 | | 6 YRS. | ONTHS DAYS | HOURS MIN. | 04/29/29 | Counti | "Marvland |
| _ | 9s. FACILITY NAME (If not institution, give | street and number) | 9 | b. CITY, TOWN C | R LOCATION OF DEA | | 9c, COUNTY OF D | |
| 5 | Mercy Hospic | / Mercy Hos | pital | Baltir | nore | | None | |
| EC | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | ITY | 10c, CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| DIRECTOR | Md Dal | | Ros | sesdale | 2 | | | LIMITS? |
| | 100. STREET AND NUMBER | timore | 1.00 | | ZIP CODE | | 10g. CITIZEN OF V | |
| FUNERAL | 6707 Haven Oa | k Rd | | | 21237 | | USA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II FORCES? 1 YES | N U.S. ARMED | 13. WAS DEC | ENDENT OF HISPANI | C ORIGIN? (Specify Yes | or No- 14. RACE | E — American Indian, |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | 1 TYES | 2 NO Specify: | , Puerto Rican, atc.) | Speci | k, White, etc. |
| | 15. DECEDENT'S ED | NICATION | 16a. DECEDENT'S US | | | | | Black |
| COMPLETED | (Specify only highest gra- | de completed) | (Give kind of wor | rk done during mos | in at of working | 16b. KIND OF BUSI | NESS/INDUSTRY | |
| 2 | | College (1-4 or 5+) Unknown | TT 1 | , | | City De | pt of I | Highway |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | LUnknown | | 18. MOTHER'S NAM | IE (First, Middle, Maiden S | | J 1 |
| BE C | Powell Fletch | her | | | Olive | Mitchell | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Town, | | |
| - | Patricia Gray | | 6707 H | laven (| Dak Rd. | Balto. C | o., Md | 21237 |
| | 20e, METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Re | moval from State 20b | D. PLACE AND DATE OF Interest, crematory or other | | | | ATION — City or To | |
| | 4 Donation 6 Other (Specify) | | | ML. | Zion | | dsdown | , Ma. |
| | AL SOMEON OF FOREIGN SERVICES | | | | D ADDRESS OF FAC | C. Jones | Funor | al Homo |
| _ | James | W.Xc | | 4611 | Park He | aighte Av | e Balto | |
| | 23. PART I. Enter the diseases, or shock, or heart fellure | r complications that caused b. List only one cause on a | d the death. Do not ach line. | enter the mor | de of dying, such | aa cardisc or respira | itory arrest, | Approximeta Interval Batween |
| | IMMEDIATE CAUSE (Final disease or condition | | | , | | | | Onset and Death |
| 1 | resulting in death) | a. Neta | Static A CONSEQUENCE OF: | Caser | 5 Cas | ocer | | ~12 mos. |
| _ | | DOE TO (OH AS A | CONSEQUENCE OF): | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | - |
| S | cause. Enter UNDERLYING CAUSE (Disease or Injury | c | | | | | | |
| | that initiated eventa resulting in death) LAST | DIE TO CON CO. | CONSEQUENCE OF): | | | | | |
| H | resoluting in death) CAST | DUE TO (OR AS A | | | | | | |
| | | d. | | | | | | |
| - 11 | PART II. Other algnificant condition | d | ut not resulting in | the underlying | cause given in P | art I. 24s. WAS AN A | JTOPSY 24b. | WERE AUTOPSY FINDINGS |
| A I | PART II. Other algnificant condition | d | ut not resulting in | the underlying | cause given in P | PERFORM | ED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| A I | PART II. Other algorificant condition | d | ut not resulting in | the underlying | cause given in P | 00000000 | ED? | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| A I | PART II. Other algnificant condition | ons contributing to deeth b | | the underlying | | 1 (1 YES 2) | ED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| A I | | ons contributing to deeth b | OF DEATH YES | Check only one) | | 1 (1 YES 2) | ED? | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| A I | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | TRIBUTE TO CAUSE O | DF DEATH YES 26. PLACE DF DEATH 4 | (Check only one) OTHER: Nursing Herne | UNCERTAIN | 1 (1 YES 2) | ED? €NO | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | TRIBUTE TO CAUSE O | PF DEATH YES | (Check only one) DTHER: Nursing Horne Off 26c. INJU | UNCERTAIN 5 G Residence 6 JRY AT NK? | PERFORM 1 TYES 2 | NO SPICE | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | TRIBUTE TO CAUSE O HOSPITAL: 1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) | 26. PLACE DF DEATH Dettent 3 DOA 4 | (Check only one) OTHER: Nursing Home OTHER: W00 1 | UNCERTAIN 5 G Residence 6 JRY AT RS 2 MO | PERFORM 1 YES 2 | DSPICE | AMALABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO |
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| BY PHYSICIAN: MEDICAL | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHY | TRIBUTE TO CAUSE O HOSPITAL: 1 Inpettent 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, stc. (Spec | 26. PLACE DF DEATH Deatlent 3 DOA 4 26b. TIME C INJUR At home, farm, stre | (Check only one) OTHER: Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing Horm Nursing | UNCERTAIN 5 G Residence 6 JRY AT RK? ES 2 NO | PERFORM 1 YES 2 M Other (Specify) HC 28d. DESCRIBE HOW IN. 28f. LOCATION (Street and City or Town, State) o the cause(a) and mannor. | SPICE JURY OCCURED d Number or Rural R | AMMILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO |
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to |
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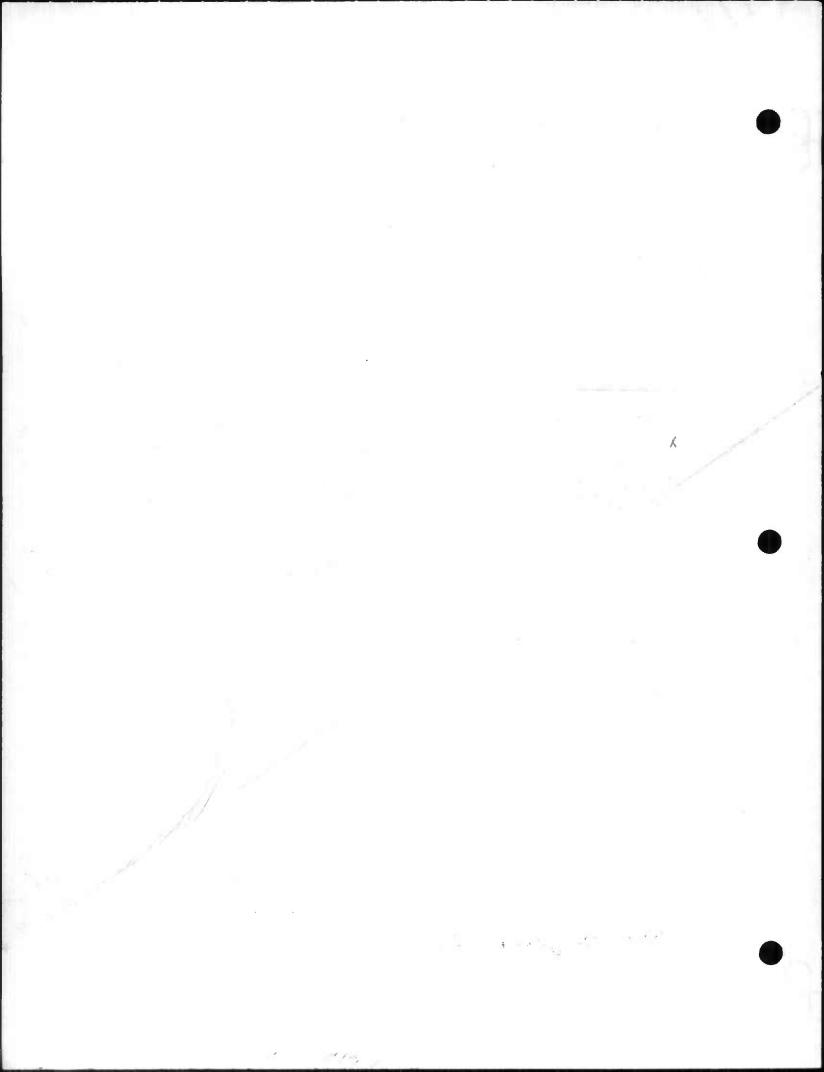
| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|------------------------------------------|-------------------------------------------------------------------|----------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATN |

| | | REGISTRAR CERTIFICATE OF DEATH | REG. NO. | |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH DAY | 3. TIME OF DEATH |
| | | Joseph E. Frazer | Aug. 31.10 | |
| | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTN | 8. BIRTNPLACE (State or Foreign |
| | | 1 M 2 F YRS. MONTHS DAYS HOURS MIN. | (Month, Day, Year) | Country) |
| 95 | | 210-10-5717 97 | 4-2-1898 | Md. |
| should | | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE | ATN 9c. COUN | TY OF DEATN |
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| - E | 3 | Catonsville, Md. | | |
| 020 physician. burial-transit | FUNERAL | 711 Maiden Choice Lane-Charlestown 21228 | U. | |
| 20 ysic | 3 | 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 1 Nover Married 12. WAS DECEDENT EYER IN U.S. ARMED 13. WAS DECEMBENT OF HISPAN 11 Yes, specify Cuban, Maxican | IC ORIGIN? (Specify Yea or No | 14. RACE — American Indian, Black, White, etc. |
| 21215-0020 of or attending physic for use as the burial | BY | IF YES, GIYE WAR OR DATES 1 YES 2 NO Specify | | Specify: |
| 5-0 anding as the | | W.W. II | | White |
| 121 atte | ED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | 16b. KIND OF BUSINESS/IND | USTRY |
| 21 21 21 21 21 | COMPLET | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) (Give kind of work done during most of working life. Do NOT use retired.) | | |
| D softal | 립 | | | |
| AND the hospit detached | ≥ | | | avy |
| Y L A | | J. Mollens I.A. | ME (First, Middle, Malden Surname) | |
| MARYLAND retained by the hospits 5 should be detached notifiled at once. | BE | Albert Frazer, Sr. Cathe | rine Wood | |
| MARY retained b 5 should notified | 6 | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural R | loute Number, City or Town, State, Zip | Code) |
| 5 5 5 | F | Bernadette Gibmeyer 604 Warwick RdB | alto Md 2 | 1220 |
| ALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-transxamilner must be notified at once. | | 20s. METHOD OF DISPOSITION 20s. BLACE AND DATE OF DISPOSITION (Name of | DATE 20c. LOCATION — | |
| OR May ector, p | 1 | 14- Burlei 2 Cremetton 3 Ramoval from State cemetery cremetery or other place) | | |
| ALTIMOR Jeath. Page 6 m funeral director, xaminer must | | Dalto National Cent 9- | 5-95 Balto. | Md. |
| death. Page tuneral dis | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | |
| AL fun fun | | Join Freder | | |
| | | G.Truman Schwab Baltimore | Md. 21229 | |
| nours after of in by the or remova | - 8 | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. | n aa cardiac or reapiretory arm | Approximate Interval Batween |
| 40 | - 1 | MMEDIATE CALICE (Final | | Onset and Death |
| 760, nd within 24 of published by fille completely fille event, the | | disease or condition resulting in death) a. Olivanced age | | ment |
| SO, withi replete crem | | DUE TO (OR AS A CONSEQUENCE OF): | | manage |
| P | | | | |
| ati Puri | CERTIFICATION | Sequentially list conditions, Aortic Stenosis | | |
| BOX cate be en hysician a prior to | E | If any, leading to immediate | | |
| | 2 | CAUSE (Disease or Injury | | |
| S, P.O. B(death certificate attending physiental Hygiene print, or other th | 느 | that initieted events DUE TO (OR AS A CONSEQUENCE OF): | | |
| - 0 5 A | 臣 | resulting in death) LAST | | |
| DS, P he death the atten Mental | | | | |
| | DICAL | PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in I | | 24b. WERE AUTOPSY FINDINGS |
| ORD that the ned by the tith and M | 5 | Archer Herris | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| res signe signe | | | 1 YES 2 NO | OF DEATH? |
| REC requires been sign of Heal | M | | _ | 1 TYES 2 NO |
| | SICIAN: | | | |
| VITAL AN: The lav tificate has e State Dep | 8 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | ck only one) | |
| /II NN:] NN:] Sta | S | HOSPITAL: 1 YES 2 DO 1 Inpetient 2 PER/Outpatient 3 DOA 4 Nursing Name 5 Residence 6 | Mar (Speciful | |
| F VIT, SICIAN: The certificate in the State | РНҮ | 27. MANNER OF DEATN 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT | 28d. DESCRIBE HOW INJURY OCC | upen |
| NG PHYS fler this ceath with | | (Month, Day, Year) INJURY WORK? | 200. DESCRIBE HOW INJURY OCC | ONED |
| ONG P OING P After death | BY | 2 Accident Investigation " 1 YES 2 NO | | |
| O NO A P | ا م | 3 Suicida 6 Could not be 28a. PLACE OF INJURY — At home, farm, streel, factory, office building, etc. (Specify) | 281. LOCATION (Street and Number | or Rural Route Number, |
| DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State I item 28 is marked, or item | ш | 4 Nomicide determined | City or Town, State) | |
| DIV OR A DIREC hours Item | Ш | 29a. CERTIFIER | | |
| 로 보는 돈 | COMPL | (Check only 1 LIPCERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the Ilms, date and place, and due | | |
| HOSPITAL FUNERAL within 72 I | ō | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the | time, data and place, and due to the | cause(a) and manner es stated. |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 | ш | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUM | BER 29d DATE | SIONED (Month, Day, Year) |
| 보 보 를 생 | ω | 7 4. 1. 1 1 man D120 | 257 1 | 3.1.91 |
| ₽ ₽ ₽ ≥ | 2 | TO NAME AND ADDRESS OF DEDSON WHO COMPLETED CALLED OF DESCRIPTION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPE | / / / / | 1.1.17 |
| / | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 12.00 | |
| (nX: | | 5601 Loch Rover Blod. Balto Md. 2. | 1139 | |
| | | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | |
| | | SEP 08 1995 Jahi Davelson hardel | | |
| | | | | |

| | | WILLIAM | 41 | 040 | F | On | 40 | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------|-------------|---------------------------|--------------|-----------|---------------------------------------|-------------|-----------|--|--|
| | 1 | 4. SOCIAL SECURITY NUMBER | 5. | SEX | 8. AGE (Ir | yrs. les | birthday) | IF UNDE | R 1 YEAR | | |
| | | 217-18-9050 | 1 | [X] M 2 □ F | 8 | 88 | YRS. | MONTHS | DAYS | | |
| 3 should | | 9a. FACILITY NAME (If not institution, | give street | and number) | | | | 9b. CIT | Y, TOWN | | |
| | <u>۳</u> | St. Agnes Hospital Balti | | | | | | | | | |
| 1, 2, | ١ĕ | RESIDENCE OF DECEDEN | IT | | | | | | T 0 T 1 | | |
| 30es | DIRECTOR | 10e. STATE 10b. CC | | 0.313 | | | | Y, TOWN | | | |
| .≓ | | Md. | | Baltim | ore | | Uw | ings | Mı. | | |
| Ded. | ₹ | 10e. STREET AND NUMBER | | | | | | | 1 | | |
| in. ansit | Ü | 107 Gwynnbro | ok A | ve. | | | | | | | |
| 020 physician. burlat-transit permit. Pages 1, | FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married | | FORCES? 1 | T EVER IN | U.S. AR | MED | 13. | WAS DE | | |
| ing ph | B≼ | 3 X Widowed 4 Divorced | | IF YES, GIVE Y | | | | | 1 🗌 YE | | |
| 215-0 attending | _ | 15. DECEDENT'S | E EDISCATI | ON | | 10- 05 | OFDENTIO | | | | |
| or after | COMPLETED | (Specify only highest | grade com | pleted) | | (G/ | CEDENT'S ve kind of a Do NOT us | work done | during in | | |
| AND 21 the hospital of detached for once. | 급 | Elementary/Secondary (0-12) | 0 | ollege (1-4 or 5 | +) | | | | | | |
| AND 2 the hospital detached to | NO | 17. FATHER'S NAME (First, Middle, Las | <u>1.</u> | N/A | | | achi | nist | | | |
| YL/ | | James Ford | | liam For | d | | | | | | |
| MAR) retained to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to should to | BE | 19a. INFORMANT'S NAME (Type/Print) |) | | | 191 | MAILING | ADDRES | g /Street | | |
| E, MARYLAN y be retained by the hos page 5 should be detach be notified at once. | 5 | Mary E. Snodg | | | | | | Land | | | |
| A 10 | | 20a, METHOD OF DISPOSITION 1 Duriel 2 Crementon 3 | | | 20b. | _ | NDDATE | | | | |
| OR e 6 mar ector, p | | 1 (X Buriel 2 Cremetion 3 C 4 Donation 5 Other (Section) | Removal | from State | ceme | tery, cre | raine | ther place | rk (| | |
| Page Page al dire | | 21. SIGNATURE OF FUNERAL SERVICE | | EE | | | | | NAME / | | |
| ALTIM death. Page funeral dir i. examiner | | 1/4/1 | | | | | | Ga | ry | | |
| BALTIMOF Is after death. Page 6 m In by the funeral director, removal. | - | 23. PART I. Enter the diseases. | 1 | | | | | | 95 | | |
| in an | | ahock, or heart fail | ium. List | only one cau | ise on ea | ch line | . DO 1 | not ente | tne m | | |
| | | IMMEDIATE CAUSE (Final disease or condition | | | CER | 111 | , | | | | |
| s760 ted within completely ial, crematic | | resulting in death) | a | DUE TO | (OR AS A | 815 | | | | | |
| s76 comp comp ial, c | 22 | | | DOE 10 | Dr 1 / | A-T | MENCE O | 4/ | 0 | | |
| SOX 68760 are be executed within 24 to ysician and completely filled prior to burial, cremation, traumatic event, the | CERTIFICATION | Sequentially list conditiona, | b | DUE TO | (OR AS A | CONSEC | UENCE O | FI: | | | |
| S, P.O. BO) death certificate be attending physician ental Hygiene prior 1 iry, or other trau | ¥ | if any, leading to immediate cause. Enter UNDERLYING | | | | | | • | | | |
| uffical uffical uffical ther | Ĕ | CAUSE (Disease or injury that initieted events | "- | DUE TO | (OR AS A | CONSEC | UENCE O | F): | | | |
| P. O. H. Cer. | F | reaulting in death) LAST | d. | | | | | | | | |
| RECORDS, P.O. BOX 68760 requires that the death certificate be executed within even signed by the attending physician and completely con Health and Mental Hyghen prior to burial, crems shows any injury, or other traumatte event, | | PART It. Other aignificant cond | distance | | d | | | | | | |
| RECORDS requires that the sen signed by the of Health and M shows any Inju | MEDICAL | PART It. Other aignificant cond | 24 / | 1arl | 1 | | Bauiting | in the u | nderlyir | | |
| RECORE v requires that the been signed by it. of Health and is shown any lin. | | Devere 1 1111 | 2 | Insuff | naev | 7 | 100 | 0 | · · | | |
| PE PE SUIT OF HE SHOW | | Thenons, | Co | rest | re | He | ark | To | ile | | |
| 23 Pept | AN | DID TOBACCO USE CO | | UTE TO CA | | DEA | 77. | 5/1 | NO L | | |
| N: The State h State item | PHYSICIA | 25. WAS CASE REFERRED TO MEDIC EXAMINER? | | OSPITAL: | | | E OF DEA | OTHE | | | |
| F VIT, SICIAN: The certificate of the State | ΙλS | 1 TYES 2 M NO | 112 | Inpatient 2 | | tient 3 | | 4 🗆 Nu | rsing Ho | | |
| NG PHYS frer this ceath with marked, | | 1 Netural 5 Pending | | 26e. DATE OF (Month, D | | | 26b. TIM | URY M | 28c. IN | | |
| ON DING After death | BY | 2 Accident Investiga | ition | 28a DI ACE O | E (b) (I IEW | 40.0 | | | 1 📋 | | |
| ISIC TTEND TTEND: # after d after d 28 is | 8 | 3 Suicide 6 Could no | | 28a. PLACE O building, | etc. (Specif | y) | ne, term, : | street, fac | tory, om | | |
| DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate ha bours after death with the State b item 28 is marked, or item: | ш | 29a, CERTIFIER | _ | 7=-7-7-7- | | | - | - | | | |
| | P P | (Check only 1 DC CERTIFYING F | | | | | | | | | |
| HOSPITAL FUNERAL WITHIN 72 MATHIN 18 | COMPLETED | 2 MEDICAL EXA | WINEH: O | n the beels of a | kamination | and/or l | nvestigatio | n, in my | opinion, | | |
| DIVISION OF VITA TO THE HOSPITAL OR ATTENDING PHYSICIAN: The TO THE FUNERAL DIRECTOR: After this certificial hee filed within 72 hours after death with the State is IMPORTANT: If Item 28 is marked, or item | BE | 96. SIGNATURE AND TITLE OF COR | TIFIER | 1200 | 1 | 0 | | | | | |
| 5 5 9 4 W | 10 | 140000 | m. | ~ | 1 | / | | | | | |
| 1 | | 30. NAME AND ADDRESS OF PERSON | | | | TH (ITEN | 27) (Type, | | MIP | | |
| 14 | | W MLOWING K | 2 | KOND | | 9 | 7 | AG | 6 | | |

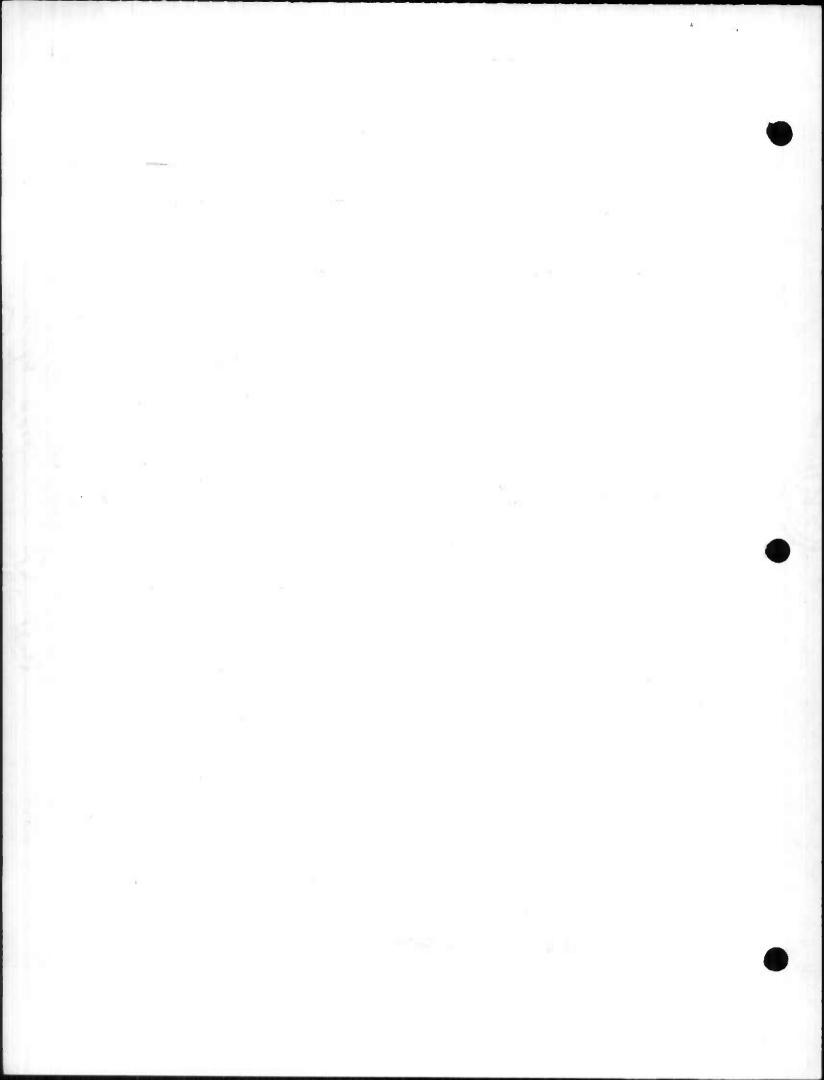
1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH AUGUST 95 6:25P M 7. DATE OF BIRTH (Month, Day, Year) MAR. 31, 1907 IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Mass. OR LOCATION OF DEATH 9c. COUNTY OF DEATH more N/A ATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO lls of, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21117 USA 14. RACE — American Indian, Black, White, etc. CENDENT OF HISPANIC ORIGIN? (Specify Yes or No-S 2 V NO Specify: Specify: white TION nost of working 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel 18. MOTHER'S NAME (First, Middle, Maiden Surname) India M. Rau and Number or Rural Route Number, City or Town, State, Zip Code) Rd., Elkridge, Md. 21227 20c. LOCATION — City or Town, State DATE Vame of 9/5 Cemetery Baltimore, Md. AND ADDRESS OF FACILITY L. Kaufman Funeral Home of Elk., Inc. Main St., Elkridge, Md. 21227 ode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 24 HRS NEUMONIA ng cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Aorho 1 YES 2 THO OF DEATH? 1 - YES 2 NO , CAD ☐ UNCERTAIN ☐ me 5 - Residence 8 - Other (Specify) JURY AT 28d, DESCRIBE HOW INJURY OCCURED YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) te end place, and due to the cause(s) and menner as stated. death occured at the time, data and place, and due to the cause(s) and menner as stated, 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 046704 AUG 31 1995 HOSP, TAL BLT MD SEP 0 81995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burifal, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be neitlified at once. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--|
| ed hours aft | filled in by on, or remo | he medica | |
| executed within a | and completely burial, crematic | traumatic event, th | |
| certificate be | ding physician Hygiene prior to | r other traun | |
| nat the death | by the atter | ny Injury, o | |
| w requires th | been signed at. of Health | 3 shows ar | |
| CIAN: The la | ertificate has | or item 2: | |
| IDING PHYSI | After this c | s marked, | |
| L OR ATTEN | L DIRECTOR: | item 28 i | |
| TO THE HOSPITA | TO THE FUNERAL | IMPORTANT: II | |
| | | | |

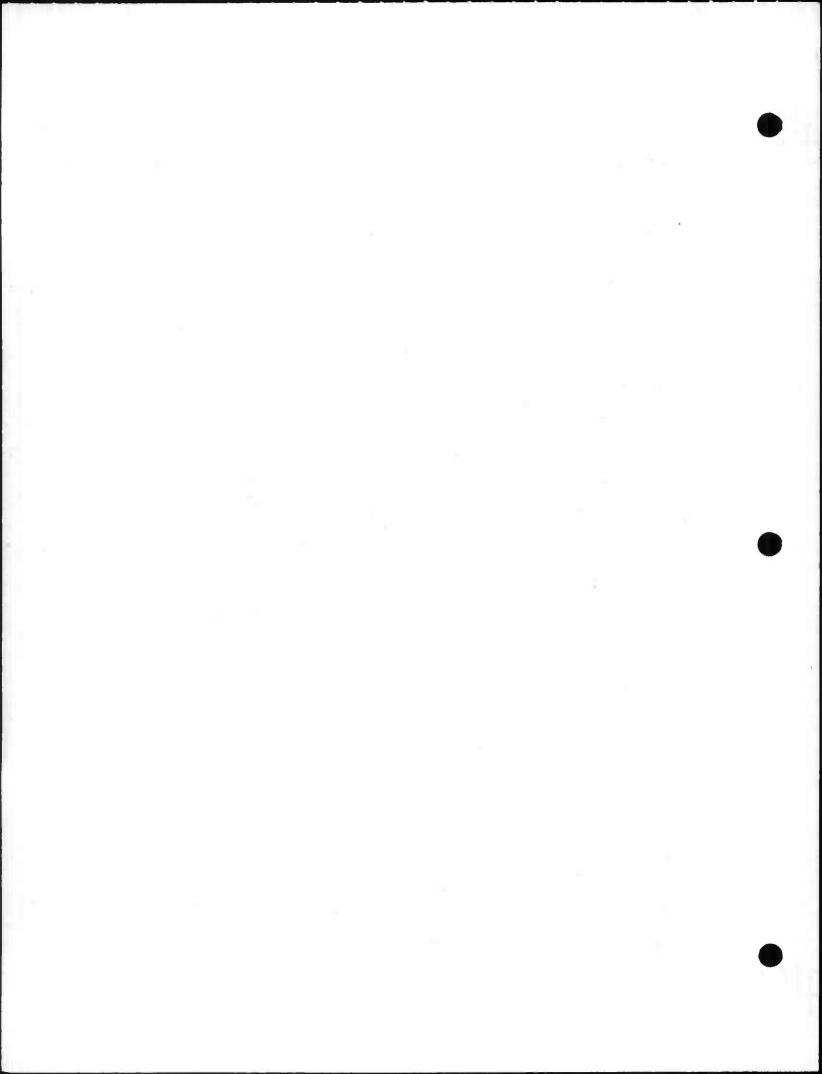
| 1. DECEDENT'S NAME (First, Middle, La | nst) | | | | | | | OF DEATH | | | 3. TIME OF DEATH |
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| JAMES | P. | | (| GENTRY | | | Sep | | 199 | EAR | 3:24 P |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. I | | UNDER 1 YEAR | IF UNDER | | | OF BIRTH 1 | | | PLACE (State or Foreign |
| 242-42-9157 | 1 🔀 M 2 🗌 F | 6 | 7 YRS. MOI | NTHS DAYS | HOURE | MIN. | Sep | t. 14, | 1927 | | Carolina |
| Se. FACILITY NAME (If not institution, ga | ive street and number) | | 9b | CITY, TOWN | OR LOCATIO | N OF DE | ATH | | 9c. COUNTY | OF D | EATH |
| Meadowridge Nur | | | | Randa | allst | own | | | Balt | tim | ore |
| Maryland 106. COL | N/A | | | own or Loca timore | TION | ď | | 5.7 | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 100. STREET AND NUMBER 1437 Stonewood | Road | | | 101, ZIP CODE 21239 | | | | | 10g. CITIZEN C | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | | | J.S. ARMED 13. WAS DECENDENT OF HISPANI 2 X NO 15 yes, specify Cuben, Mexican | | | | | NIC ORIGIN? (Specify Yee or No — 14. in, Puerto Rican, etc.) | | | : — American Indian, c, White, etc. ffy: Black |
| 15. DECEDENT'S (Specify only highest g | rade completed) | | DECEDENT'S USI (Give kind of work ife. Do NOT use re | done during m | ON ost of working | 9 | 16b. | KIND OF BUS | BINESS/INDUS | TRY | |
| 9th | College (1-4 or 5 + | | lagger | | | | B | ethleh | em Ste | 201 | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTH | ER'S NA | | liddle, Malden | | | 7.770 |
| William H. Ge | ntry | T. | 19b. MAILING AO | ADDESS /Cross | | | Dix | | a Chain Zin Co | nefe l | |
| Gladys Gentry | | | 1437 St | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 [X Burlet 2 Cremetion 3] | Removal from State | | E AND DATE OF D | | ame of | | DATE | 20c. LO | CATION - CH | y or To | wn, State |
| 4 Donation 5 Other (Specify) | 0 | | land Me | m. Par | | | 9-7 | Bal | timor | e, | MD |
| 21. SIGNATURE OF FUNERAL SERVICE | E LICENSEE | | | | | | | | | | |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without without hearth. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| E (First Middle Leet) | | | |
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| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN CERTIFICATE OF DEATH REG. NO. | E | |
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| | 1 - FOR STATE REGISTRAR | E OF MARYLAN | D / DEPAR | TMENT | OF H | EALTH | AND | MENTAL | HYGIEN REG. NO. | | | | |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------|-------------|-----------------------|---------------|---------------------------------------------------------|----------------|--------------------|-----------------------------------------|-------------------|---------------------------------------|------|
| - 3 | 1. DECEOENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE O | F DEATN | | | 3. TIME OF DEAT | Н |
| | Alice Christian GAINES | | | | | | Septe | ember | | 995 | 10:20 | рм | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In y | rs. last birthday) | IF UNDER | | IF UNDER | | 7. DATE OF | | | a. BIRTH | PLACE (State or Fo. | |
| - 4 | 234-30-2031 | 2 X F | 74 YRS. | MONTHS | DAYB | HOURS | MIN. | | 30, | 1920 | Vi | rginia | |
| _ | 9a. FACILITY NAME (If not institution, give street and n | umber) | | 9b. CITY, | TOWN O | R LOCATIO | ON OF D | | | 9c. COUN | | | |
| FUNERAL DIRECTOR | Franklin Square Hosp: | ital | | | 1 | I/A | | | | Ва | 1tim | nore | |
| REC | 10a. STATE 10b. COUNTY | | 10c. CITY | , TOWN O | R LOCAT | ION | | | | | 1 | 10d. INSIDE CITY LIMITS? | |
| □ | Maryland N/A | | Ba | ltim | ore | | | | | | | 1 X YES 2 | NO |
| ĭ. | 10e. STREET AND NUMBER | | | | 101. | ZIP CODE | | | | 10g. CITIZ | ZEN OF V | VHAT COUNTRY? | |
| Ä | 5645 Arnhem Road | | | | | 2120 |)6 | | | U | .S.A | | |
| 5 | 11. MARITAL STATUS 12. WAS 1 Never Married 2 Married FOR | DECEDENT EVER IN U.S CES? 1 YES 2 | S. ARMED | | | | | NIC ORIGIN? | | or No- | 14. RACE Bieci | — American India c, White, atc. | n, |
| ВУ | 3 🕅 Widowed 4 🗆 Divorced | ES, GIVE WAR OR DATE | S | | | 2 X NO | | | | | Speci | My: | |
| | 15. DECEDENT'S EDUCATION | 16 | a. DECEDENT'S | USUAL OC | CUPATIO | N | | 16b. K | IND OF BUS | UNESS/IND | ISTRY | Black | |
| | (Specify only highest grade completed Elementary/Secondary (0-12) College | (1-4 or 5+) | (Give kind of w life. Do NOT us | rock done d | luring mos | it of working | g | 1000 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | |
| ם | 12th | - | Domes | tic | | | | | in | own | ho | me | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTH | ER'S NA | ME (First, Mic | idle, Malden | Sumame) | | | |
| BE (| Burgess Christian | | | | | | Unk | nown | | | | | |
| 2 | 19s. INFORMANT'S NAME (Type/Print) | | 19b. MAILINO | | | | | | | | | | |
| - 1 | Polly Watson | | 5645 | Arnh | em F | Road/ | Bal | timore | e, MD | 2120 | 6 | | |
| | 20a. METHOD OF DISPOSITION 1X Burial 2 □ Cremation 3 □ Removal from | State 20b. PL. | ACE AND DATE O | F DISPOSI | TION (Ne | ne of | | DATE | | CATION — | | * | |
| | 4 Donation 5 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LICENSEE | Mou | ntain V | iew | | | | 9-9 | Alle | eghan | y Ct | y, VA | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 2 | | | | FUNE | | HOME | EAST | | | | |
| | Demand 2 | mannot | | 111 | 01 F | E. NO | RTH | AVEN | JE/BAI | LTIMO | RE, | MD 21202 | 2 |
| | 23. PART i. Enter the diseases, or complice shock, or heart failure. List only | lions that caused th | e death. Do n | ot anter | tha mod | de of dyle | ng, suc | h aa cardia | c or reapi | ratory arm | est, | Approxima | ta |
| | IMMEDIATE CAUSE (Final | _ | | | | | | | | | | Onset and | |
| 1 | disease or condition resulting in death) | Respu | ratory | 4 | ail | we | - | | | | | 45 N | un. |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | , | | | | |
| NO | Sequentially list conditions, Denote to immediate out to the conditions out to (or as a consequence of): | | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) CAUSE (Disease or injury) DUE TO (OR AS A CONSEQUENCE OF): Chrm2 Ot, 5 true twic pulminary disease gears) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 임 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CO | NSEOUENCE OF | ne o | we | Pou | cem | erias | y ac | ise as | 4- | year | 5 |
| E | resulting in death) LAST | | | | | | | | | | | | |
| | 0. | | | | | | | | | | | | |
| ¥ | PART ii. Other aignificant conditions contrib | outing to death but i | not resulting i | n the un | derlying | cause g | lven in | Part I. 2 | 4a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FIN AVAILABLE PRIOR 1 | - |
| ă | | | | | | | | 1 | YES 2 | THO | | OF DEATH? | WSE |
| E | DID TOP LOCO LICE COLUMNIA | | | - "") . | | | | | | | | 1 - YES 2 200 | 0 |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL | | PLACE OF DEAT | | | UNC | ERTAII | N | | 154 | | | |
| 2 | EXAMINER? HOSP | TAL: | | OTHER | : | | | | | | | | |
| H | | tient 2 % PR/Outpatie | nt 3 ⊔ DOA 26b. TIME | | ing Home 28c. INJU | | sidence | 6 Other (S | Specify) | I III DV OOG | UDED | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJ | | WOI | 3K? | NO. | 200. DESCR | WE HOW IF | 1JUNY OCC | UKED | | |
| ВУ | 2 Cutatta 28e | 2 PLACE OF INJURY — At home form street feeten, edition | | | | | 28f. LOCATION (Street and Number or Rural Route Number, | | | | | | |
| TED | 4 Homicide 6 Could not be determined | building, atc. (Specify) | | | | | | City or | Town, Stete) | | | Transition, | |
| COMPLET | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To to | he heet of my knowledge | a death accurre | d at the th | . 46. | | | | | Kinson | | | |
| NA I | (Check only one) 2 MEDICAL EXAMINER: On the | beals of examination an | d/or investigation | n, in my og | inion, de | ath occur | and ous | time, data an | (a) and man | ner as state | causele | and manner se et | ted |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | To place, and | | | | ned. |
| BE | aberra Ing | mo | | | | 29c. LICE | 741 | 88 | | ≥ So: | SIGNED | (Month, Day, Year) | 95 |
| 2 | 38. NAME AND ADDRESS OF PERSON WHO COMPLE | TED CAUSE OF DEATH | (ITEM 27) (Type. | Print) | | | // 6 | , 0 0 | 1000 3 | G A | I. I | () 17 | 73 |
| | | D, Frani | klih Squ | pre A | OSP | ital | Cent | to The | Buchn | wel | MA | ber 5, 19 Square 2123 | Dr |
| | 31. DATE FILED (Month, Day, Year) | REGISTRAR'S SIGNATU | RE | | | | | | | , , , | - 0 | - 5-75-3 | |
| | SEP 0 81995 July 2 | with the standard | 4 | | | | | | | | | | |

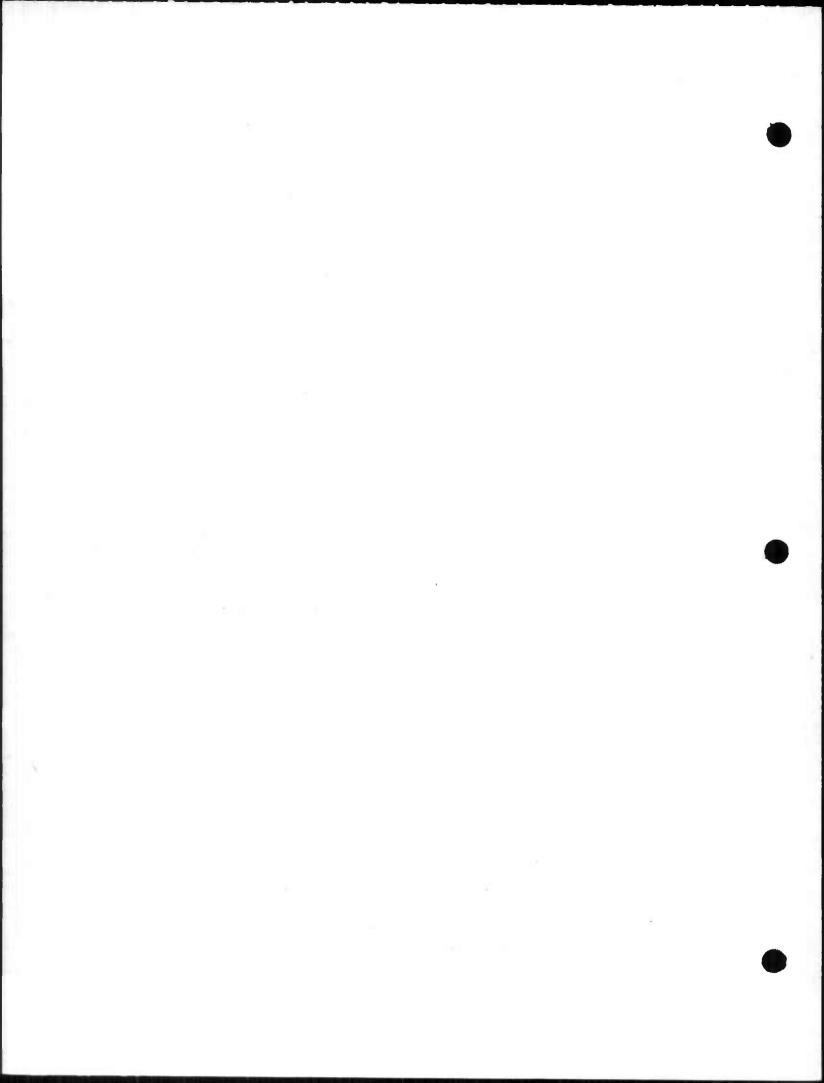


TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| | 1. DECEDENT'S NAME (First, Middle, Les | 0 | | | | 2. DATE OF DEATN | | 3. TIME OF DEATH |
| | Beverly | Gilmore | | | | 09 0 | | |
| | 4. SOCIAL SECURITY NUMBER | | | | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BH | RTNPLACE (State or Foreign untry) |
| | 213-82-8110 | 1 □ M 27€7€ | 34 YRS. | MONTHS DAYS | HOURS MIN. | 6-28-61 | | MD |
| , | 9a. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOWN O | R LOCATION OF DE | ATN | 9c. COUNTY O | F DEATN |
| R | 1400 Odessa | Ct.apt.6 | | I | Baltimo | re | n/ | 'a |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUN | | 40.077 | r, TOWN OR LOCATI | | | | 16d, INSIDE CITY |
| DIRECTOR | | | loc. Ciri | | | | | LIMITS? |
| | MD 100. STREET AND NUMBER | n/a | l | Baltir | ZIP CODE | | 100. CITIZEN C | XX YES 2 NO |
| FUNERAL | | Q1 C | | | | | log. Officers o | |
| ¥ I | 1400 Odessa | 12. WAS DECEDENT EVER | IN U.S. ARMED | | 21205 | IIC ORIGIN? (Specify Yea | or No.— 14. R | USA ACE — American Indian, |
| | 1x2Never Married 2 Married | FORCES? 1 YES | 2 NO | | cify Cuban, Maxica | n, Puarto Rican, etc.) | | pecify: Black |
| BY | 3 Widowed 4 Divorced | | 10.27 | 10.14 | AA | | | Diack |
| COMPLETED | 15. DECEDENT'S EI (Specify only highest gre | DUCATION ade completed) | (Give kind of v | USUAL OCCUPATIO | N it of working | 16b. KIND OF BUS | SINESS/INDUSTR | ٧ |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT us | se retired.) | | | | |
| MP | | 2 yrs. | Secr | etary | | | | tion Buildin |
| 8 | 17. FATNER'S NAME (First, Middle, Lest) | | | - | | ME (First, Middle, Maiden | Surname) | |
| BE | Luther Gilmo | re | Britanian. | | | Pearson | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | |
| | Ruth Gilmore | | Db. PLACEAND DATE | 0 West | | | CATION — City o | 21216 |
| | Donation 5 Other (Specify) | | emetery, crematory or of | ther placa) | | | | |
| | 11. Signamus OF FUNERAL SERVICE | LICENSEE | King Me | 22. NAME AN | Park D ADDRESS OF FA | | andall | stown, MD |
| | | am I | <u> </u> | Jame | es A. M | orton & | Sons F | uneral Home |
| _ | James | or, you | | 170 | | ns St. B | | |
| | 23. PART LEgier the diseases, of mark failur | | ed the death. Do r | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | |
| | IMMEDIATE CAUSE (Final | e. List only one cause on | | not enter the mo | de of dying, auc | h sa cardiac or reap | | Approximata interval Between |
| | | Comp | ete S | etem | de of dying, auc | has cardiac or reap | | Approximata interval Between |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other aignificant condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. 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| | Item11 9-12-95 Fill ITEM: 4. PER F.H. FILM | | | | | | 95 | 27274 |
|-------------|-------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------|---------------------------------------|----------------------|------------------------------------------------|------------------|-------------------------------------------------------------|
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | AND / DEPARTI | MENT OF H | EALTH AND I | MENTAL HYGIEN | | 1 |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | C. E | C | DEATH | 2. DATE OF DEATH MONTH D | | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | RACNEK 5. SEX 8. AGE (1) | n yrs. lesi birthdey) | F UNDER 1 YEAR | IF UNDER 24 HRS. | Sept. 8, | 1995 | 8 A. M BIRTHPLACE (State or Foreign |
| | E 14 - E 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1 M 2 F 91 | VES MC | ONTHS DAYS | HOURS MIN. | (Month, Day, Year) March 5. | | Country) Austria |
| | 9a. FACILITY NAME (If not institution, give str | set and number) | | b. CITY, TOWN O | R LOCATION OF DE | | 9c. COUNTY | |
| Į, | 12202 Fingerboa | rd Rd. | | Monrov | ia | | Frede | erick |
| DIRECTOR | Md. Frede | rick | 10c. CITY, T | Monrov | | | | 10d. INSIDE CITY LIMITS? |
| 1 | 10e. STREET AND NUMBER | LICK | | | ZIP CODE | | 10a CITIZEN | 1 YES 2 NO |
| FUNERAL | 12202 Fingerboard | Rd. | | | 1770 | | U.S. | |
| B≼ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | 13. WAS DECI If yes, spe 1 YES | city Cuban, Mexica | IIC ORIGIN? (Specify Year, Puerto Rican, etc.) | | . RACE — American Indian, Black, White, etc. Specify: |
| 9 | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION completed) | 16a. DECEDENT'S US | UAL OCCUPATIO | N II of uncking | 16b. KIND OF BU | | White TRY |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use n | | ii or working | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | HOmema | aker | 18. MOTHER'S NAI | ME (First, Middle, Maiden | Home Surneme) | |
| BEC | Leopold Sracnek | | | | | zabeth | unk. | |
| 5 | Judith A. King | | | | | Route Number, City or Tow | | * |
| | 20a, METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Ramon | 20b. | PLACEANDDATEGE | DISPOSITION /No | me of | Monrovia | CATION CIN | an Your Otras |
| | 4 Donation 5 Other (Specify) | Ве | eaver Cemetary or other | etery M | ausoleum | 7/11/95 F | chest | er, Pa. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | | 22. NAME AN | o ADDRESS OF FAC | t Funeral | Home | |
| | 23. PART I. Enter the diseases, or co | mplications that caused | the death. Do not | P.O | Box 195 | Sykesvill | e. Md. | 21784 |
| 3 | shock, or heart fallure. Li | ist only one cause on ea | ch line. | | or dying, agor | r as cardiac or respi | ratory arrest | interval Between Onset and Desth |
| | disease or condition resulting in death) | Ovani | an | line | es | | | 2/2 W |
| - | | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| RTIFICATION | Sequentially list conditions, if any, lesding to immediate | OUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| FICA | CAUSE (Disease or injury | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| 0.4.0 | that initiated events resulting in death) LAST | 302 10 (01) 10 11 | CONSECUENCE OF J. | | | | | |
| L C | PART ii. Other significant conditions | contributing to death by | it not resulting in t | tha underlying | cause given in I | Part i. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | PERFOR | MED? | AMILABLE PRIOR TO COMPLETION DF CAUSE |
| Σ | | | | | | _ | | OF DEATH? 1 YES 2 NO |
| AN | DID TOBACCO USE CONTR | | B. PLACE OF DEATH | | UNCERTAIN | 10 | | |
| PHYSICIAN: | | HOSPITAL: 1 Inpatient 2 ER/Outpa | 0 | THER: | 5 N Residence | 6 Cher (Specify) | | |
| PH | 27. MANMER OF DEATH 1 Natural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME O | F 28c, INJU | IRY AT | 28d. DESCRIBE HOW II | NJURY OCCUR | ED |
| BY | 2 Accident Investigation | 28e. PLACE OF INJURY | - At home, farm, stree | | ES 2 NO | 261. LOCATION (Street a | and Number or 6 | Print Britis Number |
| TED | 4 Homicide detarmined | building, atc. (Specif | (y) | , | | City or Town, State) | HUNNUG UF F | no er i todia i tarrioat, |
| COMPLET | | IAN: To the best of my knowle | | | | | | |
| CON | 2 MEOICAL EXAMINER: | On the basis of examination | and/or investigation, in | n my opinion, de | ath occured at the 1 | lime, data and place, an | d dua to the ce | Puse(s) and manner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 1. Kan | sol mu | 0 | 29c. LICENSE NUM | BER | 29d. OATE SI | GNEO (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, Pri | nt) | N del | 1-6 | Jegy | D 1775 |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILED (Month, Day, Year)

1995

32. REGISTRAR'S SIGNATURE Studior Roll

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) W. MARIE HARDING 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 9 -8:05 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, 225-56-2512 11 9a. FACILITY NAME (If not institution, give TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE Franklinwood acute Care Center DIRECTOR use as the burial-transit permit. Pages 1, 2, 3 It imore, Md 21237 Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Ν / A Baltimore 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3802 Nemo Road hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY SpecifyBlack 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high be detached for College (1-4 or 5+) 1.2 +h Medical Tecnician DOM 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Malden Surname) BE Thomas Hi notified Robinson funeral director, page 5 should 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Doris West 3802 nemo Road, Balto., Md.21133 e 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Memor Balto, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSFE Carlton C. Douglass 1701 McCulloh St., Balto., Md.21217 completely filled in by the rial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition the poxemia resulting in death) traumatic event, certificate be executed with DUE TO (OR AS A CONSEQUENCE OF): ysician and com retastatio Dreas Cancor Regrs CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF) that initieted eventa resulting in death) LAST 6 requires that the death signed by the atter Injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 TES 2 NO OF DEATH? shows 1 TES 3 NO t, of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. HOSPITAL OR ATTENDING PHYSICIAN; The law S 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem certificate I OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) HOSPITAL 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 6 the 27. MANNER OF DEATH 26a. DATE OF INJURY 28c. INJURY AT WORK? 26b. TIME OF marked, 28d. DESCRIBE HOW INJURY OCCURED Netural 2 Applied this with 5 Pending м 1 YES 2 NO DIRECTOR: After the hours after death v BY Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 261. LOCATION (Street 69 3 Suicide and Number or Rural Route Number COMPLETED 6 Could not be 28 4 Homicide Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIER WITHIN 72 THE IMPORTANT: If IN 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 7/95 7 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

4: is wingly good of free ...

FOR STATE

ITEMS: 23 PART I, 27, PER MEO FILM G-729 11/3/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG. NO | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------|-------------------|----------------------|----------------------------------------------|------------------|-----------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | AV YEA | 3. TIME OF DEATH |
| • | TANEHIA DEN | ISE HE | RRING | | | | 1995 | 11:15 Am |
| | | | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. BI | BTHPLACE (State or Foreign |
| | 116-76-3728 | □ M 2 🗶 F 1 | . 6 YRS. MO | NTHS DAYS | HOURS MIN. | APRIL 25 | 1979 | GERMANY |
| | 9a. FACILITY NAME (If not institution, give street | t and number) | 91 | . CITY, TOWN | R LOCATION OF DE | ATH | 9c. COUNTY C | OF DEATH |
| DIRECTOR | 9701 PARKLAND R | OAD | | PARK | VILLE | | BALTI | IMORE |
| ñ l | 10a. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCA | HON | | | 10d. INSIDE CITY LIMITS? |
| | | BALTO | I | PARKVI | LLE | | | 1 TYES 2 X NO |
| FUNERAL | 9701 PARKLAND RE |) | | 10 | 21234 | | | S.A. |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Diverced | 2. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO | 2 NO | If yes, sp | | NC ORIGIN? (Specify Yen, Puerto Rican, atc.) | | RACE — American Indian, Black, White, etc. Specify: BLACK |
| | 15. DECEDENT'S EDUCAT | ION | 16a. DECEDENT'S US | UAL OCCUPATION | ON . | 16b. KIND OF BU | | |
| | (Specify only highest grade cor | | (Give kind of world life. Do NOT use n | done during mo | | | | |
| COMPLETED | 11TH | N/A | ST | UDENT | 1 | | N/A | |
| 8 | 17. FATHER'S NAME (First, Middle, Lest) | | | OD LIVE | | ME (First, Middle, Malden | | |
| BE C | REGINALD HERRIN | IG SR. | | | DEN | SE GRIE | FIN | |
| 10 | 190. INFORMANT'S NAME (Type/Print) REGINALD HERRIN | IG SR. | | | | BALTO, N | | |
| | 20a, METHOD OF DISPOSITION 1 X Surial 2 Cremation 3 Remove | | GARRISON | | | OATE 20c. LC | INGS N | |
| | 4 Donation 5 Other (Specify) | | | | ND ADDRESS OF FA | | | TIBBO, ND |
| | FXADA Y | March | | MAF | CH F/H- | WEST 340 | | ASH AVE |
| | 23 PART I. Enter the diseases, or cor | | | enter the reg | de of dying, suc | h as cardiac or resp | iratory arreat, | Approximata |
| | shock, or haert fallure. Lis | it only one cause on a | ach lina. | | | | | Interval Batween Onset and Death |
| | disease or condition | CARDIAC ARRI | HYTHMIA | | | | | |
| | reaulting in deeth) a. | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| z | Constitution and the constitution of the | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | DUE TO (OR AS | CONSEQUENCE OF): | | | | | |
| 2 | CAUSE (Disease or Injury | | | | | | | |
| H | thet initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| EH | d. | | | | | | | |
| | PART II. Other algnificent conditions | contributing to death is | out not resulting in | the underlyin | g cause given in | Part I. 24s. WAS AI | | 24b. WERE AUTOPSY FINDINGS |
| DICAL | | | | | | PERFO | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| ED | | | | | | | | OF DEATH? |
| Σ. | DID TORACCO USE CONTRIL | BUTE TO CAUSE O | E DEATH YES | ПИОГ | 1 UNCERTAIL | v n | | 1 123 2 100 |
| AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | |
| PHYSICIAN: ME | | OSPITAL: | netlant 3 DOA 4 | THER: | ne 500 (taaldence | 6 (Other (Specify) | | |
| H | 27. MANNER OF DEATH | 28e. DATE OF INJURY | 28b. TIME (| - | JURY AT | 28d. OESCRIBE HOW | INJURY OCCURE | D |
| | 1 XX Natural 5 Pending | (Month, Day, Year) | RULVIS | | YES 2 NO | | | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | / — At home, farm, stre | et, factory, offi | ia. | 28f. LOCATION (Street | | ural Route Number, |
| TED | 3 Suicide 8 Could not be determined | building, etc. (Spe | cify) | | | City or Town, State |) | |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29e. CERTIFIER (Check only one) 1 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and man | | | | | | | | |
| ME I | one) * MEDICAL EXAMINER: | On the beals of examination | n and/or investigation, | In my opinion, | death occured at the | time, data and place, a | nd due to the ce | use(a) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CHRTIFIER | 1 00 | 7 | | 29c. LICENSE NUI | MBER | 29d, DATE SIG | INED (Month, Day, Year) |
| BE | Whit | -Dall N | £ AL. | | O.C.M | . E | | T. 04,1995 |
| 2 | 30. NAME AND ADDRESS OF PURION WHO | | | | 1 | | | |
| | MARIO 7. KID | | M1 Penn | Stre | et, Bal | timore, | 21201 | |
| | 31. DATE FILED (Month, De) Year) | 32. REGISTBAR'S SIGN | NATURE ROAD | 1 | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020**

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| THE HOSPITAL OR ATT THE FUNERAL DIRECTOR filed within 72 hours aff PORTANT: If Item 28 | ENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | | ter death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after death IMPORTANT: If Item 28 Is ma | PHYSICIAN: Th | this certificate | with the State | irked, or Iter |
| THE HOSPITAL OR I THE FUNERAL DIRECTION TO THE MICHING TO THE MICHING TO THE MICHING TO THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING THE MICHING TH | TTENDING | | after death | 28 Is ma |
| THE HOSPI THE FUNER filed within | TAL OR A | AL DIRE | 72 hours | If Item |
| | THE HOSPI | THE FUNER | filed within | IPORTANT |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| • | FOR STATE REGISTRAR | TATE OF MARYLAND / | DEPARTMENT | | IENTAL HYGIENE REG. NO. | | | |
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| | 1. DECEDENTS NAME (First, Middle Last) | r. Hall | | | 2. DATE OF GEATH | 1.995 3. T | 8:00 A M | |
| | | 8. AGE (In yrs. las | | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 1/31/1919 | e. BIRTHPLAC Country) VIRGI | E (State or Foreign | |
| OR | 9a. FACILITY NAME (If not institution, give street a 5718 HIGHGATE I | | | NOWN OR LOCATION OF DEA | 9c. (| 9c. COUNTY OF GEATH | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE MARYLAND N | /A | 10c. CITY, TOWN OR | LOCATION | | 2 | INSIDE CITY LIMITS? YES 2 NO | |
| FUNERAL | 10e. STREET AND NUMBER 5718 HIGHGATE DE | RIVE | | 10f. ZIP CODE 21215 | 10g. | CITIZEN OF WHAT | COUNTRY? | |
| BY FUNE | 1 Never Married 2 Married | was deceoent ever in u.s. ar forces? 1 X YES 2 P IF YES, GIVE WAR OR DATES 10/8/43 12/3 | 10 11 | AS DECENDENT OF HISPANI yea, specify Cuben, Maxican YES 2 NO Specify: | | Black, Wh | merican Indian, ita, etc. | |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade company) | ON 18a. DE (G | CEDENT'S USUAL OCC hie kind of work done du . Do NOT use retired.) | iring most of working | 166. KIND OF BUSINESS | | | |
| COMPLETED | 6th | Por | klift Op | | | | | |
| ш | 17. FATHER'S NAME (First, Middle, Last) ROBERT HALL | | | | IE (First, Middle, Maiden Surnar IA LOUISE | | -1.54 | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) LOUISE V. TOMS | | | | oute Number, City or Town, State BALTIMORE, | | 215 | |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | from State cometers on | AND DATE OF DISPOSIT | REST VET. | 1 | N — City or Town, S | | |
| | 21. SIGNATURE OF FINERAL SERVICE LICENSE | | 22. N | AME AND AODRESS OF FACE BROY O. DY | | FUNERAI | HOME | |
| | 23. PART Lines the diseases, or companies. Liet IMMEDIATE CAUSE (Final disease or condition resulting in death) | plications that couled the de only one cause on each line | | | as cardiac or respiratory Tailune Disease | | Approximate interval Between Onset and Death | |
| CERTIFICATION | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | DUE TO (OR AS A CONSE | OOLINGE OJ. | Artery | Disease | | | |
| PHYSICIAN: MEDICAL CE | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY PERFORMED? PERFORMED? PERFORMED? PERFORMED? PERFORMED? PERFORMED? OF DEATH? 1 YES 2 NO | | | | | | | |
| CIAN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: | | | | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | Inpatient 2 ER/Outpetient 3 28a. DATE OF INJURY (Month, Day, Year) | | ng Homa 5 Realdenca 28c. INJURY AT WORK? 1 YES 2 NO | 8 Other (Specify) 28d, DESCRIBE HOW INJURY | Y OCCURED | | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28s. PLACE OF INJURY — At he building, atc. (Specify) | ome, term, street, tecto | ry, office | 281, LOCATION (Street and Nu City or Town, State) | imber or Rural Route | Number, | |
| COMPLETED | CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTRUCTION OF THE CONSTR | N: To the best of my knowledge, do not the bests of examination and/or | | | | | J manner as stated. | |
| TO BE C | 29b. SIGNATORS AND TITLE OF CERTIFIER | /wwD | | D42 | 96 P | Sept | 6 (1995 | |
| | 30. NAME AND ADDRESS OF PERSON WHO CO | uch 3 | O (St | Paul | Suite | 907 | 21202 | |
| | SEP 0 81995 | 32 REGISTRAR'S SIGNATURE | Salt: | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

| | REGISTRAR | | CE | RTIF | ICATE (| OF DE | ATH | 1 | REG. NO. | | | |
|----------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|-----------------------------|-------------------------|------------------------|---------------------------------------------|----------------------------------------|------------------------------|---------------|----------------------------|-------------------------------------------------------------|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) George | W | | | На | rgesi | Ė | 2. DATE OF NO€TH Sept | DEATH DA | | YEAR 1995 | 3. TIME OF DEATH 3:55a.M |
| 0.000 | 4. SOCIAL SECURITY NUMBER 215-10-6112 | 5. SEX 8. 1XX M 2 F | AGE (In yrs. less | t birthday) YRS. | IF UNDER 1 Y | EAR IF U | NDER 24 HRS. RS MIN. | 7 DATE OF | | | 8. BIRTH | PLACE (State or Foreign |
| ~ | 9e. FACILITY NAME (If not institution, give s | | | | | | CATION OF DE | | | 9c. COU | NTY OF D | EATH |
| DIRECTOR | Stella Maris Hosp | 1ce | | | Tows | son | | | | Bal | Ltimo | ore |
| REC | 10a. STATE 10b. COUNTY | | | 10c. CITY | r, TOWN OR L | | | | | _ | | 10d. INSIDE CITY LIMITS? |
| 0 | Maryrand | timore | | | 101 | vson | | | | | | 1 YES 2 X NO |
| VERAI | 160 Piccadilly Ro | | | | | 10f. ZIP (| 21204 | 4 | | | JSA | WHAT COUNTRY? |
| COMPLETED BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2XX Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? X X IF YES, GIVE WAR | VER IN U.S. ARI YES 2 NO OR DATES W 11 | MED IO | if ye | s, specify (| NT OF HISPAN Cuban, Mexica NO Specify | NIC ORIGIN? (S in, Puerto Rica y | Specify Yea in, atc.) | or No — | 14. RACE Black Speci | - American Indian, k, White, atc. //y: White |
| 입 | 15. DECEDENT'S EDUC (Specify only highest grade | ATION completed) | (Gi | ve kind of w | USUAL OCCU | PATION og most of w | rorkina | 16b. Kil | ND OF BUS | INESS/IN | DUSTRY | |
| APLE | Elementery/Secondary (0-12) 12 yrs. | College (1-4 or 5+) N/A | life. | _{∞ мот из} Jyer | e retired.) | | | Hu | tzler | r's [| Dept. | Stores |
| | 17. FATHER'S NAME (First, Middle, Last) George Hargest | | | | | 18, 6 | | Foste: | | Surname) | | |
| TO BE | 190. INFORMANT'S NAME (Typo/Print) Carole Coleman | | | | | | | Route Number, | | | | |
| | | | | | | _ | ve. Ba | altimo | | | | |
| | 20s. METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Remote 4 Donation 5 Other (Specify) | wal from Stata | Balti | MODATE O | PER CENE | N(Name of tery | 9-6-9 | 95 DATE | | | city or To | wn, State Iryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | essahn | | | 740 | Ol Be | lair F | | 36 | | | |
| | 23. PART i. Enter the diseasea, of c shock, or heart fallura. | omplications that ca | used the da | eth. Do n | ot enter the | moda of | dying, suc | h aa cardlac | or reapi | ratory ar | reat, | Approximate |
| i. | IMMEDIATE CAUSE (Final | 100000 | | | rimo | · ma | ر | | | | | Interval Between Onset and Death |
| | resulting in death) | Aspira Due to lor | AS A CONSEC | UENCE OF |): | | | | | | | |
| NO. | Sequentially list conditions, if any, leading to immediate | DUE TO (OR | VASCI AS A CONSEC | WENCE OF | - A | ide | nt | | | | | mos. |
| <u>S</u> | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | DUE TO (OR | AS A CONSEC | UENCE OF |): | | | | | | | |
| | PART II. Other significant condition | contributing to dea | ith but not re | eultlog l | n the under | tulna cau | ee alven la | Don't L au | a. WAS AN | | | |
| EDICAL | | | in out not re | southing in | ii tire unuai | lying cau | aa giveii in | | PERFOR | MED? | 246. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | 1123 2/ | 1110 | | OF DEATH? 1 YES 2 NO |
| CIAN: M | DID TOBACCO USE CONTE | IBUTE TO CAUS | | | | | NCERTAIN | V 🗆 | | | | |
| SIC! | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | | H (Check only OTHER: | | 190000 | | | | | |
| PHYS | 27. MANNER OF DEATH | 28a. DATE OF INJU | JRY | 28b. TIME | OF 280 | INJURY A | | 6 Other (Sp 28d, DESCRI | | JURY OC | CURED | |
| BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Y | ber) | INJ | | WORK? | 2 🗌 NO | | | | | |
| COMPLETED | 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE OF IN. building, etc. | JURY — At hor (Specify) | ne, lerm, s | treet, fectory, | office | | 28f. LOCATIO City or To | ON (Street as own, State) | nd Number | or Rural R | loute Number, |
| P.E. | 29a. CERTIFIER 1X CERTIFYING PHYSIC | CIAN: To the beat of my | knowledge, des | ith occurre | d at the time, | data and p | laca, end due | to the cause(s | a) and man | ner as sta | ted. | |
| M O | | R: On the basis of exami | | | | | | | | | |) and menner as stated. |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 01 | 71 | | | 29c. | LICENSE NUN | IBER | | 29d, DAT | E SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | Taule | ulli | √ | Christi | | 256 | 43 | | > C | 1/5/ | 195 |
| | KR-Paulkner | 2300 I | F DEATH (ITEM | ley | Salle | Re | \$/B | elto | ME | 00 | 20 | 4 |
| | SEP 0 8 1995 | file alude | SIGNATURE | 40 | (|) . | | | | | | |

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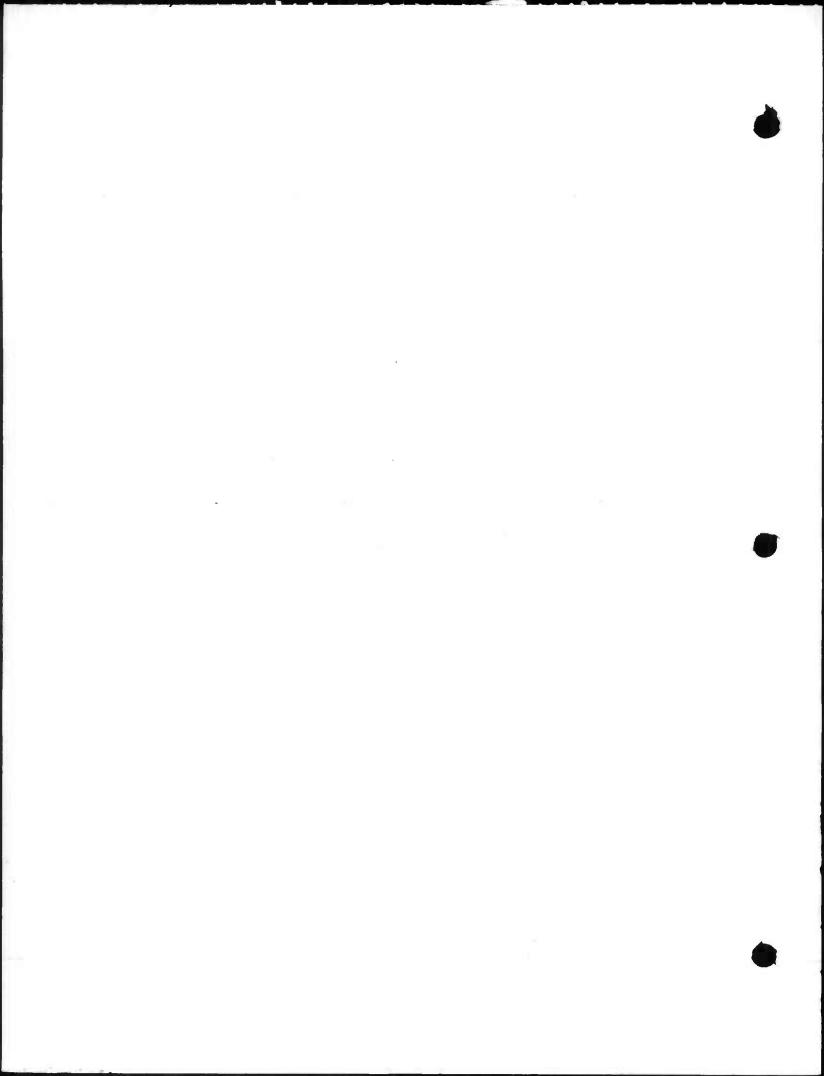
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any interpretable of may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | 1. DECEDENT'S NAME (First, | Adiciello (ant) | | | | | | | | | HEG. NO. | | | |
|---------------|------------------------------------------------------------------|-------------------------|--------------------------------|---------------------|----------------------------|-------------|-------------|---------------|------------|------------------|---------------------|------------|--------------|-------------------------------------------|
| | MARY CATHE | | IANCEN | | | | | | | 2. DATE OF MONTH | DEATH | AY | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 8. AGE (In yrs. les | 4 6 2-45 - 3 | | | | | 7. DATE OF | 7. | | 95 | 2240 M |
| | 218-32-8333 | | 1 M 2 X F | 93 | YRS. | MONTHS | DAYS | HOURS | MIN. | MARCH | BIRTH Pay, Year) | 1000 | S, BIRTI | HPLACE (State or Foreign ry) LTIMORE |
| | 9a. FACILITY NAME (If not in | | 21. | 93 | 1110. | as orr | TOWARI A | OR LOCATI | | | 29, | | DAI | |
| œ | CARROLL COU | | , | CDTTAT | | 200 | | MINST | 7.1 | AIH | | | ARROI | |
| DIRECTOR | RESIDENCE OF DEC | | MERAL HO | BLITAL | | V | WES II | TIND | LEK | | | U. | INKUI | ىلد |
| Ä | 10e. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND | CARRO | LL | | | | H | AMPS1 | read | | | | | 1 TES 2 NO |
| ₹ | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP COD | _ | | - | | | WHAT COUNTRY? |
| 崱 | 3409 SCHAFE | R DRIV | E | | | | | 2107 | 74 | | | J | J.S.A | A. |
| FUNERAL | 11, MARITAL STATUS 1 Never Married 2 | Manufact | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | | 13. | WAS DEC | ENDENT C | OF HISPAN | IIC ORIGIN? (| Specify Yes | or No- | 14. RACI | E — American Indian, k, White, etc. |
| B | 3 Widowed 4 Divo | 10.00 | IF YES, GIVE W | AR OR DATES | | | | 2X□ NO | | | | | Spec | WHITE |
| | 15. DEC | EDENT'S EDUC | CATION | 18a. DE | CEDENT'S | USUAL O | CCUPATIO | NA. | | 185 K | IND OF BUS | INESS (IN | THIE TOV | WHILE |
| | (Specify only Elementery/Secondary (0 | highest grade | completed) College (1-4 or 5 - | (G | ive kind of v Do NOT us | vork done | during mo | st of working | ng | 100. 10 | ND OF BU | PINEGG/IN | DOSINI | |
| P | 8TH GRADE | 12, | Conege (1-4 or 5 t | | HOMEM | IAKEI | R | | | | HOI | MEMAI | KING | |
| COMPLETED | 17. FATHER'S NAME (First, M | iddle, Last) | | | | | | 18. MOTI | HER'S NA | ME (First, Mid | dle, Meiden | Sumeme) | | |
| BE | BERNARD ROD | LER | | | | | | | ANNA | A | (UNKI | (NWON |) | |
| 2 | 19e, INFORMANT'S NAME (7 | | | | | | | | | Route Number, | | | p Code) | |
| - | PAUL F. HAN | SEN | | 1. | 204 F | RANC | CIS | AVENU | JE – | BALTI | MORE | , MD | 21 | 1227 |
| | 20s. METHOD OF DISPOSITION 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | n 3 🗆 Ramo | oval from Stata | 20b. PLACE / | MAD DATE (| OF DISPOS | SITION (Ne | me of | | DATE | 20c. LO | CATION - | City or To | own, Siste |
| - 1 | 4 Donation 5 □ Other | | event) | MEADO | WRIDG | | | | | | ELI | CRIDO | GE | |
| | | 6 | Chise | All | | | | RD FU | | AL HOM | E. II | NC. | | |
| | 1 em | | D mi | al | | 41 | 107 | VILKE | ENS A | AVENUE | -BAL | LIMOE | RE, N | D 21229 |
| 1 | 23. PART i. Enter the di shock, or he | seases, or c | omplications the | t caused the de | sth. Do n | not anter | r the mo | de of dy | ing, auci | h es cerdis | c or respi | ratory sr | rest, | Approximete interval Batween |
| | IMMEDIATE CAUSE (Fir | el. | 1 | | | 1 | 6 | | | | | | | Onset and Death |
| | disesse or condition resulting in death) | + , | . Xarge | Bowel | Ot | istra | chi | | | | | | | 2464. |
| | | | | | | | | | | | | | | |
| S S | Sequentially list conditi | ons, | DUE TO | ficulty | NIENCE OF | F): | | | | | | | | |
| CERTIFICATION | If any, leading to immed cause. Enter UNDERLY | | | | | | / | | | | | | | j |
| Ĕ | CAUSE (Disesse or inju that initiated eventa | γ 🧎 ° | CARCI | (OR AS A CONSEC | DUENCE OF | P): | | | | | | | | |
| | resulting in death) LAS | T . | 1, | | | | | | | | | | | |
| | PART II. Other significa | nt conditions | s contribution to | death but not r | eaulting i | in the m | ndechilm | | alica la | Doet 1 a | | | Lan | |
| MEDICAL | | | - contributing to | death bot hot i | oourting i | iii tale ul | iluer iyiri | , cause i | Aran in | Part I. 24 | PERFOR | | 246 | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | — I ¹ | YES 2 | DE NO | - 1 | DF DEATH? |
| | DID TOBACCO U | SE CONITE | DIDLITE TO CA | LICE OF DEA | TU VE | · - | NO E | 1 11516 | TOTAIN | | | Į. | | 1 TYES 2 DNO |
| Y N | 25. WAS CASE REFERRED TO | | CIBUTE TO CA | | E OF DEAT | | | 1 ONC | EKIAII | 1 🗆 📗 | | | Щ. | |
| PHYSICIAN: | EXAMINER? 1 YES 2 ONO | | HOSPITAL: | | | OTHE | A: | . f 🗆 Da | aldenne | 6 Other (S | Sanak i | | | |
| <u></u> | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 28b. TIM | E OF | 28c. INJ | URY AT | Taldellice | 28d. DESCR | | NJURY OC | CURED | |
| BY P | | Pending nvestigation | (Month, D. | ay, vear) | INJ | URY M | | RK? (ES 2 | NO | <u>_</u> | | | | - |
| | 3 Suicide 8 | Could not be | 28e. PLACE O | F INJURY — Al ho | me, farm, a | treet, fec | tory, offic | | | | ON (Street a | nd Number | r or Rural I | Route Number, |
| 2 | 4 Homicide | ietermined | | | | | | | | C., C. | own, oteley | | _ | |
| COMPLETED | 29e. CERTIFIER (Check only | IFYING PHYSIC | CIAN: To the best of | my knowledge, da | eth occurre | d at the t | time, data | end place. | , end dua | to the cause | (a) and man | ner se sta | ted. | |
| 8 | | | | | | | | | | | | | | a) and menner as stated. |
| шШ | 296. SIGNATURE AND TITLE | OF CERTIFIER | | | | | | 29c. LICE | NSE NUN | IBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| <u>اا</u> ۵ | -50 | ugh | 00 | | | | | D : | 2196 | 12_ | | | 9/6/ | 195 |
| 임 | 30. NAME AND ADDRESS OF | | | | | | | | | | | | , , | |
| | S. P. | GIRDH | AR MI |) | 217 | WA | S/11 n | 16 70 | N H | HEIGHT | B. | VIST | MINT | TER DD ZIIT7 |
| | 31. DATE FILED (Month, Day. | | / | R'S SIGNATURE | | | | | | | | | | |
| | SEP 0 819 | 95 9 | the offered | colones | | | | | | | | | | |
| | | | | | | | | | | | | | | DHMH-16 Rev 1/89 |



3. TIME OF DEATH

DHMH-18 Rev 1/89

REG. NO

2. DATE OF DEATH MONTH

1 -

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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336 HERTA **JONES** 9/5/95 A SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 4/10/57 & AGE (In ure lest hirthday 5. SEY IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreig 1 M 2 🗆 F MONTHS DAYS HOURS MIN. 38 YBS 587 92 4450 mISSISSIPPI Be. FACILITY NAME (If not institution, give street end number 96 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1814 n. CALVERT ST DIRECTOR BALTIMORE BALTO CITY 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTO. CITY MD. BALTIMORE 1# YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? USA 1814 N. CALVERT ST. 21202 burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO JF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. It yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify: BY 3 Widowed 4 Divorced the AFR. **AMERICAN** as COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade use Flementary/Secondary (0-12) College (1-4 or 5 +) ò UNKNOWN UNKNOWN detached 12 0 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) **JESSIE** THOMAS ALBERTI NE should be JONES Ħ BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 page 5 s ALBERTINE JONES 1409 GUSRYAN ST. BALTO. MD 9 20e. METHOD OF DISPOSITION

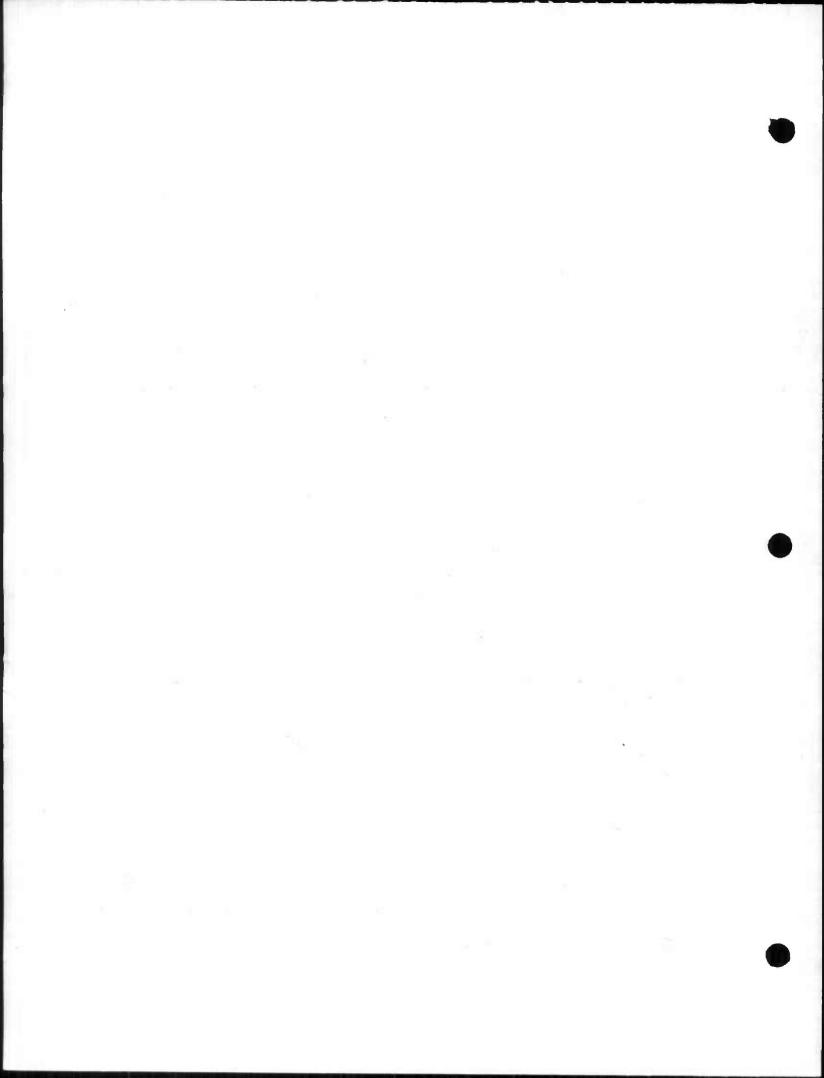
1 ∰ Burlel 2 □ Cremetion 3 □ Removal from State

4 □ Donetion 8 □ Other (Spagify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town State DATE must director, MT. 210N other 97/8/95 LANSDOWNE, MD. examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY n by the funeral d ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. medical filled in by t Approximate intervai Between within 24 hours Onset and Death IMMEDIATE CAUSE (Final the cremation. disease or condition DUE TO (OR AS A CONSEQUENCE OF): MINJE completely resulting in death) event. burial, years executed OUE TO (OR AS A CONSCOUNCE OF): other traumatic CERTIFICATION and Sequentially list conditions, attending physician a ntal Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING Man Imm holy icing 2 certificate CAUSE (Disease or injury that initiated events reaulting in death) LAST FATRA V Enous Dru 6 n signed by the attend f Health and Mental H death Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY the MEDICAL END STAY PERFORMED? AMAILABLE PRIOR TO Renal amy that COMPLETION OF CAUSE 1 YES 2 140 OF DEATH? shows Amen in 1 TYES 2 90 NO has been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Пеш DIRECTOR: After this certificate I hours after death with the State HOSPITAL OTHER: 1 YES 2 NO □ Inpetient 2 □ ER/Outpetient 3 □ DOA PHYSICIAN 6 27. MANNEY OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Netural 5 Pending М 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 99 4 Homicide 28 determined E Hem 8 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. COMPL TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: It is (Check only one) nation end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE. 034334 19 reene 10 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

METY DISCUSS FACILITY 315%. CALVET Bultmore SEP 0 8 1995 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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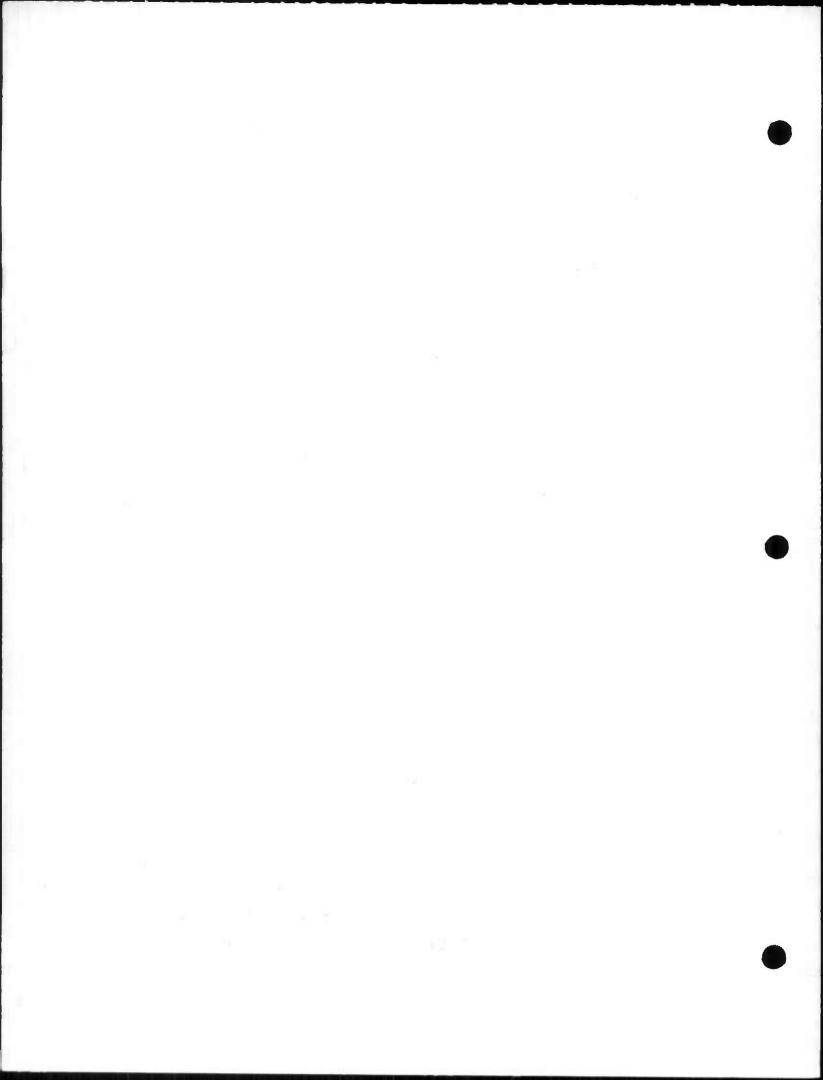
| | 1 - STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | ENTAL HYGIEN | _ | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------|------------------------|-------------------------------------------------------------|----------------------------------------------|--------------------|----------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | . Jor | | | 2. DATE OF DEATH | MY YE | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | n yrs. lest birthday) | IF UNDER 1 YEAR | | Sept.4, | | 5:15 A |
| | 216-20-3256 9s. FACILITY NAME (If not institution, give | 1 💢 M 2 🗆 F 6 | | MONTHS DAYS | HOURS MIN. | (Month, Dey, Year) | | Maryland |
| TOR | | ital Center | | | .City,M | | | ione |
| DIRECTOR | 10s. STATE 10b. COUNT | none | | town on Locat | ty,Md. | | | 10d. INSIDE CITY LIMITS? 1XXYES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | Cross St. | | 101 | 21230 | | | of WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2. Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp- | ENDENT OF HISPANIC ecity Cuben, Mexicon, 2 NO Specity | | e or No— 14. | RACE — American Indian, Black, Whita, etc. Specify: White |
| TED | 15, DECEDENT'S EDI (Specify only highest grad | UCATION (e completed) | 16a. DECEDENT'S I (Give kind of w life, Do NOT use | rork done during mo | | 16b. KIND OF BU | SINESS/INDUST | |
| COMPLET | Elamentary/Secondary (0-12) 10th.Grade | none | Mecha | | | | .G.E. | |
| | 17. FATNER'S NAME (First, Middle, Last) George | Jones | | | 18. MOTHER'S NAME | E (First, Middle, Meider Se11 | | |
| TO BE | t9a. INFORMANT'S NAME (Type/Print) Mrs.Irene V. | | | | and Number or Rural Ros | ute Number, City or Tov | vn, Stete, Zip Coo | ie) |
| | 20s. METNOD OF DISPOSITION 1 Ry Burlel 2 Cremetion 3 Rer 4 Donation Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | noval from State ceme | PLACE AND DATE Of elery, cremetory or oil en Have | en Memo | orial Pk | . 9/7/95 B | alto.N | Burnie, Md 4d.21230 E.Fort Av |
| CERTIFICATION | 23. PART I. Enter the diseases, or shock, or haart failure immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | B. DUE TO (OR AS A DUE TO (OR AS A C. | nch lina, | 7): - ~ (- 1 | | | | Approximate Interval Between Onset and D |
| EDICAL | PART II. Other significant condition | ons contributing to death be | ut not resulting i | n the underlying | g causa given in P | | RMED | 24b. WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 P NO |
| SICIAN: M | DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 28. PLACE OF DEAT | N (Check only one) | | | | |
| BY PHYS | 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIMI | E OF 28c. INJ | DURY AT CORK? YES 2 NO | 28d. DESCRIBE NOW | INJURY OCCUR | ED |
| ETED B | 3 Suicide 6 Could not be 4 Nomicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, a | street, factory, offic | : | 281. LOCATION (Street City or Town, State | | Rural Route Number, |
| COMPLE | one) | SICIAN: To the best of my knowl | | | | | | ouse(s) end manner as state |
| H | 29b. SIGNATURE AND TITLE OF CERTIFI | ER | | | 29c. LICENSE NUMB | | 29d. DATE SI | OMED (Mopin, Day, Year) |
| 5 | 30. NAME AND ADDRESS OF PERSON W | NO COMPLETED CAUSE OF DE | ATN (ITEM 27) (Type, | Print) | 7 5. 1 | | i S | ~ |
| | 31. DATE FIS END 10 8 1995 | FEGILLEAR'S SIGN | ACHE | | / | | | |

| BALTIMORE, MARYLAND 21215-0020 | ours after death. Page 6 may be retained by the hospital or attending physician. | I in by the funeral director, page 5 should be detached for use as the burial-tran |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1 54 1 | ly filler |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | . OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran |

ısit permit. Pages 1, 2, 3 should TO BE COMPLETED BY FUNERAL DIRECTOR TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - STATE REGISTRAR | STATE OF MARYL | | | ENT OF H | | | MENTAI | HYGIENI REG. NO. | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------|---------------|-------------------|---------------|-----------|-------------|----------------------------------|------------|--------------------------|--------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | · | | | | | | MONTE | OF OEATN | γ | YEAR | 3. TIME OF DEATH |
| | ZRA | KENN | | | | | SEF | | , 19 | | 13:30 P M |
| | SEX 6. AGE | (In yrs. lest birth | RS. MONT | THE DAYS | HOURS | MIN. | (Month | OF BIRTH | 05 | Count | " |
| 9e. FACILITY NAME (If not institution, give street | | 10 | | CITY, TOWN C | R LOCATIO | N OF OE | | t 4, 19 | | Mas: | sachusetts DEATH |
| 138th. & OCEAN | | | 0 | cean (| itv | | | | WOR | CHE | STER |
| RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | 100 | | WN OR LOCAT | | | | | | | 10d. INSIDE CITY |
| Massachusetts Suffoli | k | | | ca Pla | | | | | | | LIMITS? |
| 10e. STREET AND NUMBER | | | | 101 | ZIP COOE | | | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| 28 Cedarwood Road | | | | C | 2130 | | | | Uni | | States |
| 11. MARITAL STATUS 1 X Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | 2 VINO | | If yes, sp- | cify Cuben | | n, Puerto I | l? (Specify Yes Rican, atc.) | or No- | 14. RACI Blec Spec | E — American Indian, k, White, atc. My: White |
| 15. DECEDENT'S EDUCAT (Specify only highest grade con | | | | AL OCCUPATION | | | 16b | . KIND OF BUS | INESS/INI | DUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do N | VOT use reti | red.) | si or working | , | | | | a 1 | |
| 17. FATNER'S NAME (First, Middle, Lest) | | Stude | ent | | 40 440744 | | | lement | | Scho | 001 |
| James Francis Kenne | edv | | | | 13.1 | | | Klein | | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 19b, MA | VILING ADD | RESS (Street e | | | | ber, City or Town | | Code) | _ |
| Thomas M. Kennedy | | 945 | 8 Wh | ite Sp | ring | Way | Co | 1umbia | , Ma | ry1a | ınd 21046 |
| 20a. METNOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 M Remove | I from State Ce | b. PLACE AND D | ry or other p | lece] | | | DAT | | | | own, State |
| 4 Donation 6 Other (Specify) | SEE Me | ount Au | uburr | 22. NAME A | | | 9/6 | Camb | orade | ge, I | Massachusett |
| Start 7 | Ho | | | Mitch | e11-V | Wied | efel | d Home | | | |
| 23. PART I. Enter the diseases, or con | nolications that cause | d the death. | Do not a | | | | | | | | land 21212 |
| ahock, or heart fellure. Lie IMMEDIATE CAUSE (Finel disease or condition resulting in death) | DROW DUE TO (OR AS | 30 | (NCE OF): | | | | | | | | Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | | | | | | | | | | |
| PART II. Other algnificent conditions | contributing to deeth | but not resul | iting in th | ne underlyin | g cause g | Iven in | Part i. | 24a, WAS AN PERFOR 1 YES 2 | MED? | 24 | b. WERE AUTOPSY FINDINGS AWILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DID TOBACCO USE CONTRIB | BUTE TO CAUSE O | OF DEATH | YES [| □ NO [| UNC | ERTAI | N | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | 26. PLACE OF | - | heck only one) | | | | | | | |
| | ☐ Inpatient 2 ☐ ER/Ou | | | Nursing Non | IURY AT | sidence | | SCRIBE HOW I | IN O | | N |
| 1 Natural 5 Pending | (Month, Day, Year) | - 10 | A 20 P | W | PRK? | NO | 200. DE | DROW) | ME | COMEO | |
| Accident Investigation Suicide 6 Could not be | 200. PLACE OF INJUR | | farm, stream | t, factory, offic | | | 26f. LOC | ATION (Street | and Numbe | r or Rural | Route Number, |
| 4 Homicide determined | building, atc. (Sp | OCI | EAN | | | | Ö | OFAN | CIT | YIN | MAYLAND |
| 29e. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the beat of makeno | wiedgs, death o | occurred at | the time, date | end place, | and due | to the ca | use(s) and mer | mer as sta | ited, | |
| one) 2 TMEDICAL EXAMINER: | on the basis of exeminati | on end/or inves | atigation, in | my opinion, | leath occur | ed at the | time, date | and place, en | d due to 1 | the ceuse | (s) end menner es stated. |
| 291 SIGNAPORE AND TITLE OF CENTIFIER | | | | | 29c. LICE | NSE NUI | MBER | | 29d. DA | TE SIGNE | D (Month, Day, Year) |
| | for Y | | D /T | -41 | (| OCM | E | | S | EPT | .03,1995 |
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ROBERT YEAR SERTEMBER. EUGENE 3:00 AH KEYS 1995 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) MARLY LAND 212-26-0231 1 M 2 - F OCHOBER Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE 555EX 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE ESSEX 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21221 FRENCHS AVE use as the burial-transit attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TES 2 NO Specify: ВҮ 3 Widowed 4 Divorced Specify: WHITE 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during life. Do NOT use retired.) 5 funeral director, page 5 should be detached for College (1-4 or 5+) retained by the hospital 124R5 BALTO. COUNTY SCHOOL SCHOOL TEACHER 6 YRS 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle WILLIAM TEYS BE EDNA notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 WOODSIDE AVE BALTO MD be 20e, METHOD OF DISPOSITION
1 M. Burial 2 Cremetion 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of must PARKWOOD 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNDRAL SURVICE LICENSEE EVANS CHAPEL OF 21234 8800 filled in by the fi Whi HARFORD medicai 23. PART Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximate shock, or heart fallure. List only of Interval Between IMMEDIATE CAUSE (Finel Onset and Death cremation, the diseese or condition DUE TO (OR AS A CONSEQUENCE OF): pletely 6 hours event. resulting in death) COM and com traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury prior other DUE TO, (OR AS A CONSEQUENCE OF)thet initieted events resulting in death) LAST 1 month 0 the atten iniury. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY and and ашу signed I 1 - YES 2 NO DF DEATH? Shows 1 TES 2 NO been . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES ☐ NO ☐ UNCERTAIN ☐ has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) Hem certificate the State HOSPITAL: OTHER: 1 - YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA ng Home 5 Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 26d. DESCRIBE HOW INJURY OCCUREO marked, this (with 1 属 Netural м 1 YES 2 NO ΒY After Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED DIRECTOR: / 4 Homicide 28 29e. CERTIFIER

There and 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, end due to the cause(e) end menner se stated. 2 MEDICAL EXAMINER: On the basis of examinstion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 10 minter D4196 ans 91 6 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL MARTIN 1576 MERRITT BLUD. PUNDAL July 32 A RESERVE S CANALLY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

| | 1 - STATE REGISTRAR | Leeth | | | | | | DEATH AND | | REG. NO. | _ | | 3. TIME OF DEATN |
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| | 1. DECEDENT'S NAME (First, Middle WILLIAM | i, Liest) | | I | EARY | 7 | | | | PT. 5 | , 19 | 95 | 3:25 P. |
| | 4. SOCIAL SECURITY NUMBER 245-54-3709 | 5. SE | X M 2 🗆 F | 6. AGE (In yrs. le | est birthday) YRS. | IF UNDER | 1 YEAR DAYB | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | of BIRTH | 1937 | Nor | PLACE (State or Foreign th Carolir |
| H. | 8e. FACILITY NAME (If not institution HOWARD CO. | | | ITAL | | | | CO . C | | hia | 9c. COUN | | EATN |
| DIRECTOR | RESIDENCE OF DECEDE | | | | 10c. CIT | ry, town o | | | Olan | 1.00 | | | 10d, INSIDE CITY |
| | Maryland 1 | N/A | | | В | altir | | . ZIP CODE | _ | | 10g. CITIZ | EN OF W | VHAT COUNTRY? |
| NERAL | 14 E. Madiso | | | December 1 | | | | 21202 | | | U.S | .A. | |
| BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Marrie 3 Widowed 4 Divorced | ed FC | AS DECEDENT DRCES? 1 (YES, GIVE W | EVER IN U.S. A YES 2 AR OR DATES | NO | | yes, spe | ENDENT OF NISF ecify Cuben, Max 2 1 NO Spe | can, Puerto | | n or No | Black | - American Indian, t, White, atc. White |
| TED | (Specify only higher | 1 | | (| DECEDENT'S (Give kind of the. Do NOT u | work done i | CUPATIO | ON st of working | .16 | . KIND OF BU | SINESS/IND | USTRY | |
| once. COMPLET | Elementary/Secondary (0-12) | | ege (1-4 or 5+) | <u>'</u> | Insta | ller | | | | | truct | ion | |
| 111 | Jesse James . | | | | | | | Minni | | Middle, Melden ie Rod | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Pri | | | | | | | nd Number or Run 504, F | | | | , | 28311 |
| must be | 20a METNOD OF DISPOSITION 1 1 Buriel 2 Cremation 3 4 Donation 6 Other (Special | | om State | | e and date creditatory or o Lawn | | | | 9- | | cation - c | | |
| examiner | 21. SIGNATURE OF FUNERAL SER | VICE LICENSEE | 7 | -/ | , | Ma | itth | ews Fun | eral | | | | |
| | | ea, or compli | cationa that | caused the | deeth. Do | | | | | | | | 21224 Approximate |
| traumatic event, the medical | shock, or heart find the same or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | ellure. Liet or | ATH ET DUE TO | se on eech lir | SNOT | not enter | the mo | Eastern de of dyling, a | och aa car | rdiac or reap | iratory arm | | Approximate Interval Bats |
| or other traumatic event, the ERTIFICATION | shock, or heart for immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) | ellure. Liet or | DUE TO | OR AS A CONS | NOTA | not enter | the mo | de of dylng, a | och aa car | rdiac or reap | iratory arm | | Approximate Interval Bety |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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| BE | Otto Manke 19a. INFORMANT'S NAME (Type/Print) | _ | 405 444 11 1010 | 10000000 | | thel H | | | | | | |
| 임 | Lillian Skidmore | | | ADDRESS (St | | | | | | | | |
| | 20a. METHOD OF DISPOSITION | 100 | | | | Ave. | | | | | 21084 | |
| | 1 Donation 5 Other (Specify) | val from State CE | b. PLACE AND DATE | ther place) | | | DATE | | OCATION — C | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | lew Oakla | | | DRESS OF F | pt 11 | , 19 | 95 Syk | esvı | lle, Md | • |
| | ×41. 1.5 | 41.11 | | 12.70 | IL AND AD | | | Funer | ral Ho | me | | |
| Щ | Harry TU. | Hayst | | Р. | O.Box | 195 | Sykes | ville | e, Md. | 217 | 84 | |
| | 23. PART I. Enter the diseases, or co shock, or heart failure. Li | implications that ceus- ist only one cause on | ed the death. Do a | not enter the | mode of | dying, aud | ch as card | ac or reap | olratory arre | nt, | Approximat | |
| | IMMEDIATE CAUSE (Final | | A | 1 \ | -) i | | | | | | Onset and | |
| | disease or condition resulting in death) a. | Vontric | wan | 1 | 1:6 | al | ion | | | | Dungs | TWI |
| | | DUE TO (OR AS | A CONSEQUENCE O | F): | | Di -1 | | 1 | · # | | 100 | |
| NO N | Sequentially list conditions, b. | DUE TO (OR AS | A CONSEQUENCE OF | ujoe | 000 | ८,व्य | a | uje | vec | M | 200 | 20 |
| Ä | if any, leading to immediate cause. Enter UNDERLYING | (OII NO | A CONSCOURAGE OF | 0 | | | | V | | | i | 0' |
| | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | | <u> </u> | |
| ERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| O | PART II Other elevisions conditions | | | | | | | | | _ | | |
| AL. | PART II. Other algnificant conditions | contributing to death | but not resulting | In the under | fying caus | se given in | Part I. | 24a. WAS AN PERFO | | | YERE AUTOPSY FIN | |
| MEDIC | | | | | | | | 1 YES | 2 1 10 | | OMPLETION OF CA | AUSE |
| M | DID TOR LOCALIST | | | | | | _ | | | 1 | ☐ YES 2 ☐ NO | 0 |
| SICIAN: | DID TOBACCO USE CONTRI | BUTE TO CAUSE (| | | | NCERTAI | N 🗆 | | | | | |
| 5 | | HOSPIPAL: | 26. PLACE OF DEAT | OTHER: | one) | | | | | | | |
| ΥS | 1 YES 2 JUNO | 1 A Impatient 2 - ER/Ou | | 4 🗆 Nursing | | | | | | | | |
| PHY | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | | URY | WORK? | | 28d. DESC | CRIBE HOW | INJURY OCCU | RED | | |
| A | 2 Accident Investigation | | | | ☐ YES | 2 NO | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, atc. (Spi | Y — At home, farm, a scify) | street, tectory, | office | | 28f. LOCA City of | TION (Street Town, State | and Number of | Rural Rou | ite Number, | |
| Ē, | | | | | | | | | | | | |
| COMPLETED | | AN: To the best of my kno | | | | | | | | | | |
| ŏ | 2 MEDICAL EXAMINER: | On the besis of examinati | on and/or investigation | n, in my opinie | on, death o | ccured at the | time, data s | and place, a | nd due to the | cause(s) e | nd manner sa sta | rted. |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 15 | | | 29c. | LICENSE NUI | MBER | | 29d. DATE | SIGNED (M | fonth, Day, Year) | |
| TO B | Comingelled | 4 Noga | me | | I | 181 | 20e | 3 | P C | 1/0 | 19x | |
| | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF D | | | | ~ | | | | | | |
| | 700-A POD | e ld | Westa | i MI | 1 | LU) | 8 | ull | 57 | | | |
| | SEP 0 8 1995 | 32. DEGISTRAR'S SIG | VATURE | | | | | | (| | | |
| | CLD II o luuk (// | / // // // // // // // // // // // // / | | | | | | | | | | - 1 |

by the hospital or attending physician.

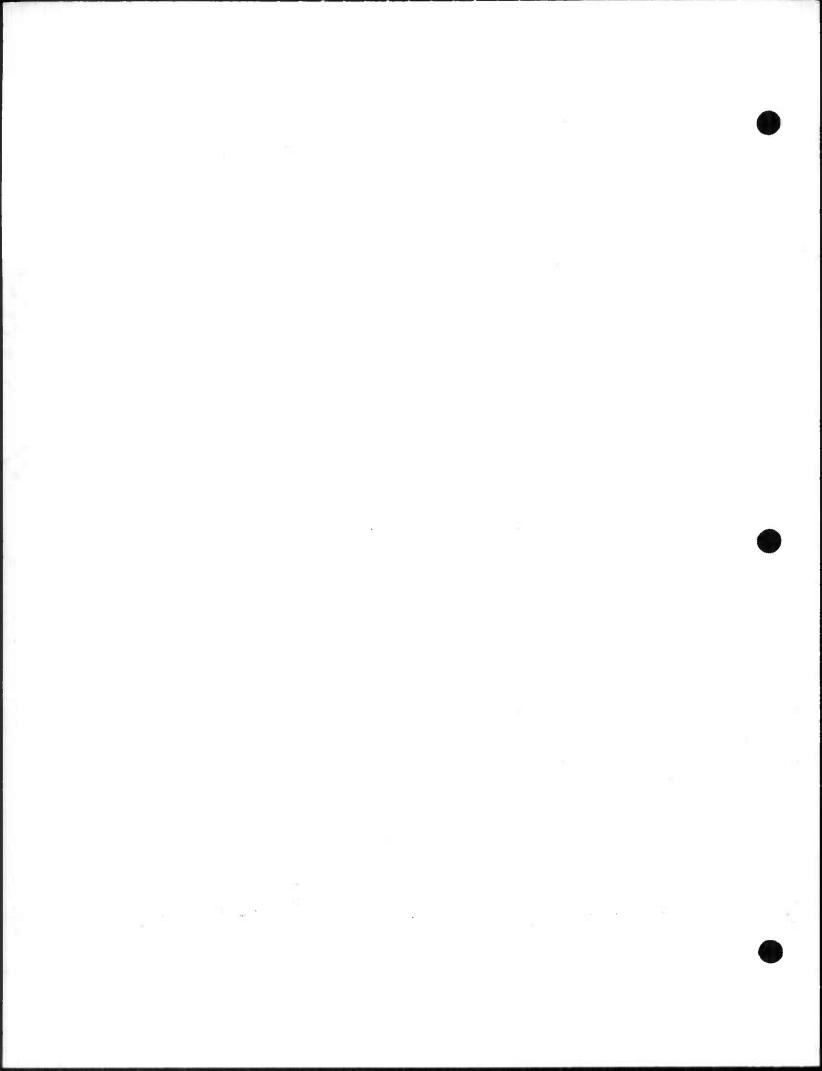
I be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

6+1

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after de TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after death with the State Dept. of Health and Mental Hygene prior to burial, cremation, or removal. IMPORTANT: if Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical ex- | | TO THE MUSTIAL OF ALLENDING PHYSICIAN: The law requires may the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | th and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Nem 28 Is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 10 THE HOSPITAL OR ATTENDING PHYSICIAN: The OTHE FUNERAL DIRECTOR: After this certificate have filed within 72 hours after death with the State OMPORTANT: If Nem 28 is marked, or item? | | aw requires mar me o | s been signed by the | ept. of Health and Mei | 3 shows any Injur | |
| o the Hospital or Atten o the Funeral Director: Merian 72 hours after Mportant: If New 28 I | A CONTRACTOR OF | DING PHYSICIAN: The | After this certificate ha | death with the State D | s marked, or item | |
| | TO THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH | U INE HUSPIAL ON ALLEN | THE FUNERAL DIRECTOR: | he filed within 72 hours after | MPORTANT: If Item 28 i | |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAI | | MENT OF H | | | YGIENE EG. NO. | | | | | |
|-------------|--------------------------------------------------------------------------------------------------------|------------------------------|----------------------|-----------------------------------------------------|------------------------------------|-----------------|------------------------------|---------------|--------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF D | | | 3. TIME OF DEATN | | | |
| | Robert V. Meek: | ins Jr. | | | | монтн 09- | 03 -1 | 995 | 1500 nm | | | |
| | 4. SOCIAL SECURITY NUMBER 5. | SEX 6. AGE (In | yrs. lest birthdey) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | RTN | S BIOTHE | LACE (State or Foreign | | | |
| | 22 2 2 2 1 1 2 2 2 | X M 2 □ F 61 | YRS. | IONTHS DAYS | HOURS MIN. | | 28,1934 | Mar Mar | yland | | | |
| œ | 9e. FACILITY NAME (If not inetitution, give etreet 17 Kinship Road | and number) | R LOCATION OF D | EATH | | INTY OF DE | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | Dund | атк | | В | altir | nore | | | |
| E | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY | | | |
| 6 | Md. Bal | ltimore | | Dund | alk | | | | LIMITS? | | | |
| A | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CIT | | AT COUNTRY? | | | |
| FUNERAL | 17 Kinship Road | | | | 21222 | | | | | | | |
| 5 | | . WAS DECEDENT EVER IN U | | 13. WAS DEC | NOENT OF HISPAI | NIC ORIGIN? (Sp | ecify Yea or No- | 14. RACE | - American Indian, | | | |
| BY | 1 X Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1X YES | | | city Cuben, Mexica 2X NO Specif | | atc.) | | White, etc. | | | |
| | | | Army | | | | | Whi | te | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade com | DN pleted) | 6a. DECEDENT'S U: | SUAL OCCUPATION ric done during mo- retired.) | N I of working | 16b. KIND | OF BUSINESS/IN | DUSTRY | | | | |
| ۱۳ | Elementary/Secondary (0-12) C | college (1-4 or 8 +) | Cler | | | v | M.C.A. | | | | | |
| \$ | 17. FATNER'S NAME (First, Middle, Lest) | | CICI | 7. | | | | | | | | |
| | R. Virgil Meek | ins. Sr. | | | | | Malden Surneme) Steven | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 11107 011 | 10h MAN ING A | DDDEED (Dww) | nd Number or Rural | | | | | | | |
| 2 | Robert Jackson | | | | | | | | . 21030 | | | |
| | 20g_METHOD OF DISPOSITION 1 \(\times \text{Burlet} \) 2 \(\text{Cremation} \) 3 \(\text{Removal} \) | | LACEANDDATEOF | | | | 20c. LOCATION - | | | | | |
| | 1 (2 Burlet 2 Cremation 3 Removal 4 Donation 6 Other (Specify) | from State Comete | Tawn | v pleant | | | | | | | | |
| | 21. SIGNATURE OF TUNERAL SERVICE LICENS | | LDGWII | 22. NAME AN | D ADDRESS OF FA | CILITY | | | 21222 | | | |
| | » 40.00 - V | 1/2/ | • | | ey-Ash | | | | , Inc. | | | |
| \dashv | 23. PART I. Enter the diseases, or com- | cours | h - 4 - 4 - D | 2134 | Willow | Sprin | ig Rd., | Ba1t | | | | |
| | shock, or heart failure. List | only one cause on eac | h iine. | | | | | reat, | Approximata interval Between | | | |
| | iMMEDIATE CAUSE (Final disease or condition | Chronic | 1 chami | c boss | semilia | I dia | 061 0 1 | | Onset and Death | | | |
| ŀ | reaulting in death) a | DUE TO (OR AS A C | 0110501151105-05 | | | | court | | 7 years | | | |
| _ | | DOE TO (OH AS A C | ONSECUENCE OF): | | | | | | , , | | | |
| <u>é</u> | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| HTIFICATION | cause. Enter UNDERLYING | | | | | | | | | | | |
| Ē | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A C | ONSEQUENCE OF): | | | | | | | | | |
| Ē | reaulting in death) LAST | | | | | | | | | | | |
| 5 | PART II. Other aignificant conditions co | ontributing to death but | mat consisting to | Abo moderal lan | | p | 551 | | | | | |
| 3 | TANT III OTHER BESTING CONDITIONS OF | mulbuding to death but | not resulting in | tne underlying | cause given in | | WAS AN AUTOPSY PERFORMED? | - A | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO | | | |
| MEDIC | | | | | | 10 | YES 2 NO | | OMPLETION DF CAUSE OF DEATH? | | | |
| 2 | DID TOPACCO LISE CONTRIB | LITE TO CALICE OF | DEATH VEC | W | | | / | 1 | YES 2 ND | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIB | | DEATH YES | | UNCERTAIN | <u>ч П</u> | | | | | | |
| 2 | EXAMINER? | OSPITAL: | 10 | THER. | 1.0 | | | | | | | |
| Ě | 27. MANNER OF DEATN | Inpatient 2 ER/Outpatie | 28b. TIME (| | 5 Reeldence | | cify) E HOW INJURY OC | CHRED | | | | |
| | Natural 6 Pending | (Month, Day, Year) | INJUE | M 1 Y | HC? | 200. 020011101 | L HOW INSURT OC | CONED | - 1 | | | |
| B ₹ | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJURY - | At home, ferm, stri | | | 28f. LOCATION | (Street and Numbe | r or Rural Ro | ute Number | | | |
| COMPLETED | 4 Nomicide determined | building, atc. (Specify) |) | | | City or Tow | n, Stete) | | | | | |
| ۳ ا | 290. CERTIFIER 1 CERTIFYING PHYSICIAN | : To the best of my knowled | as death occurred | et the time date | and allows and due | to the country | | | | | | |
| \$ | | n the beele of examination e | | | | | | | and menner as stated. | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 1 | 29c. LICENSE NUN | | | | | | | |
| 8 | J. Crostan Of | fondom, 1 | и. В. | | DO 76 | | 29d. DA1 | Q _ 7 | Aonth, Day, Year) | | | |
| 2 ∥ | 30. NAME AND ADDRESS OF PERSON WHO CO | MPLETED CAUSE OF DEATI | H (ITEM 27) (Type, P | rint) | | | | L - | 13 | | | |
| | J. CROSSAN C | +AVONOU"C | V. m.D. | 211 | L DUN. | DALK | AVE. | BA | to mi | | | |
| | SEP 0 8 1995 | 32. REGISTRAR'S SIGNATI | Lett | | | | | | 21222 | | | |



| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| | - | |

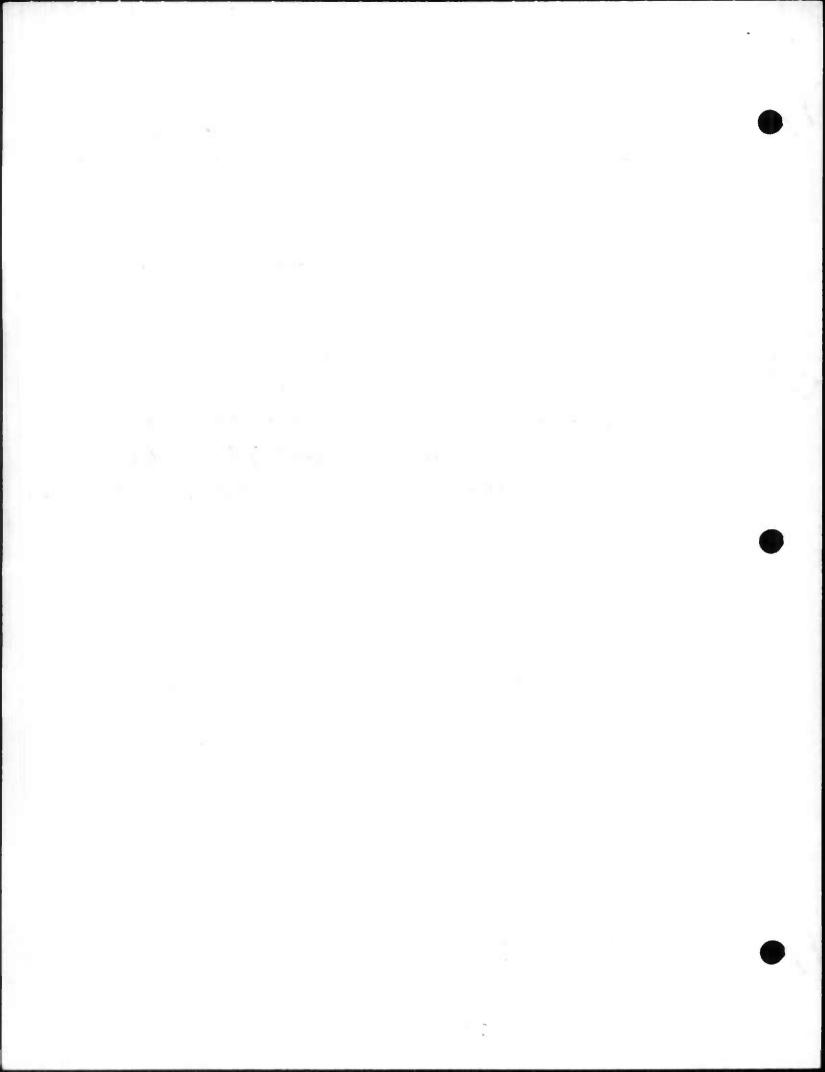
| | litm: /. P | ER F.H. | | | | | | | | | | | | |
|---------------|---------------------------------------------------|--------------------------|----------------------------------------|------------------------------------|-----------------|------------------------|-------------|-------------------|-----------|----------|---------------------------------------|-----------------------------|-------------------|---------------------------------------------|
| | 1 - STATE REGISTRAR | | STATE OF M | / MARYLAND / | DEPAR | RTMENT | OF H | DEAT | AND I | MENT | AL HYGIEN REG. NO | E | | |
| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | E OF DEATN | | | 3. TIME OF DEATH |
| | Sidney | | David | m | 119 | alis | 5 | | | AUG | ivst 18 | \ \ / | 995 | 1724 nu |
| | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (In yrs. les | | # UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DAV | E OF BIRTH 2 | / | 6 BIRTH | PLACE (State or Foreign |
| | 212 24 20 | 95 | 1 🔀 M 2 🗆 F | 65 | YRS. | MONTHS | DAYS | HOURS | MIN. | Api | mil *20 | ,19 | B O COUNTY | aryland |
| | 9a. FACILITY NAME (If not in | stitution, give s | street and number) | | | 9b. CITY, | TOWN C | OR LOCATI | ON OF DE | | | | NTY OF D | |
| R | Shady Gro | ve Ad | lventist | Hospi | tal | Ro | ckv | ille | 9 | | | | | mery |
| ਹੋ | RESIDENCE OF DEC | EDENT | | | | | | | | | | | | * |
| DIRECTOR | | | | | | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland | Monto | jomery | | FO. | toma | C | | | | | | | 1 YES 2 NO |
| FUNERAL | 10s. STREET AND NUMBER | | | | | | 101 | . ZIP CODI | | | | - 17 | | HAT COUNTRY? |
| Ä | 9229 Padd | ock I | | | | | | 208 | 354 | | | USA | Ä | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 | Mandad | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | MED | 13. 1 | MAS DEC | ENDENT C | F HISPAN | HC ORIG | IN? (Specify Yes o Ricen, etc.) | or No- | 14. RACE Block | — American Indian, , White, etc. |
| ВУ | 3 Widowed 4 Divo | | IF YES, GIVE W | | | 1 | YES | 2 NO | Specify | /: | o rincari, accep | | 1 2 | Mite |
| | 15 DEC | EDENT'S EDU | CATION | He DE | CEDENTIO | USUAL OC | V04404714 | | | | | 10.75.07 | | |
| Ë | (Specify only | highest grade | completed) | (G | ive kind of | work done of retired.) | turing mo | n st of workin | g | | Sb. KINO OF BUS | HNESS/INC | DUSTRY | |
| 2 | Elementary/Secondary (0 | -12) | College (1-4 or 5 d | +) | | , | | | | nih: | tant | Seli | F-Em | ployed |
| COMPLETED | 17. FATHER'S NAME (First, MI | dolle. Lest) | - | 1001 | | | 421 | | | | , Middle, Maiden | | | Field |
| Ö | Harry Mar | golis | | | | | | | | | Brenn | , | | |
| 0 | 194. INFORMANT'S NAME (7) | 2 | | 191 | . MAILING | ADDRESS | (Street a | | _ | | mber, City or Tow | | Code | |
| 임 | Florence | M. Ma | argolis | | | as i | | | | | on on on | , 01010, 24 | , 0000) | |
| | 20A. METHOD OF DISPOSITI | ON 1 | | 20b. PLACE | | | | | | _ | TE 20c. LO | CATION - | City or To | wn. Stata |
| | 1 Tonation 5 Other | | oyal from State | Judea | matory or o | emor | ial | Gdi | ns | 1 | | | | land |
| | 21. SIGNATURE OF FUNERAL | SERVICE LIC | ENGEE | | | 22.1 | NAME AN | D ADDRES | SS OF FA | | uneral | 77.00 | - | |
| - | Theres | 14 | 1. | 6 | | | | | | | | | nes | |
| - | 23 BART L 53 | 44 | Man | XX. | | | | Chi | | | | | | |
| - 1 | 23. PART I. Erter the di sheek, or he | easea, or coart fellure. | Complications the List only one cau | t caused the de se on each line | ath. Do i | not enter | the mo | de of dy | ng, sucl | h aa ca | rdiac or respi | ratory arr | reat, | Approximate interval Between |
| - 1 | disease or condition | oi . | | | | | | | | | | | | Onset and Death |
| | resulting in death) | → | a. Acut | OR AS A CONSEC | ard. | ial | Inf | arc | tior | 1 | 13.50 | | 7.71 | 20 min |
| _ | | | | | | | | | | | | | | years |
| O | Sequentially list conditions, | | | | | | | | | | | | | |
| Ä | if any, leading to immed cause. Enter UNDERLYI | NG | | etes M | | | | | | | | | | years |
| 필 | CAUSE (Disease or injust that initiated events | y | u | (OR AS A CONSEC | | | | | | | | | | 7002 |
| CERTIFICATION | reaulting in deeth) LAST | · (. | d. | | | | | | | | | | | |
| 2 | DARK II Ontra de Illiano | | | | | | | | | | | | | 1 |
| ¥ | PART II. Other algnificer | t condition | e contributing to | death but not re | eeuiting | in the un | derlying | cause g | iven in | Part i. | 24a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICA | | | | | | | | | | | 1 TES | NO X | | COMPLETION OF CAUSE OF DEATN? |
| | | | | | | | | | | | | | | 1 TYES 2 NO |
| PHYSICIAN: | DID TOBACCO US | | RIBUTE TO CA | | | | | UNC | ERTAIN | 4 🗆 | | | | |
| 5 | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER | | | | | | | | |
| YS | 1 TYES 2 NO | | 1 Inpatient 2 | | | 4 🗆 Nurs | | 5 🗆 Re | eldenca | 6 🗆 Ott | ner (Specify) | | | |
| | 27. MANNER OF DEATH | Pending | 28a. DATE OF (Month, Di | | 28b. TIM INJ | URY | 28c. INJI | RK? | | 28d. DI | ESCRIBE NOW IF | JURY OCC | CURED | |
| à l | 2 Accident | nvestigation | | | | м. | | ES 2 | NO | | | | | |
| | | could not be etermined | building, | F INJURY — At horetc. (Specify) | me, ferm, : | street, 1ecto | ery, office | | - 1 | 28f. LO | CATION (Street a y or Town, State) | nd Number | or Rural R | oute Number, |
| <u>u</u> | An- OFFICER | | | | | | | | | | | | | |
| COMPLETED | (Check only | | CIAN: To the best of | | | | | | | | | | | |
| Š. | 2 MEDIO | CAL EXAMINE | R: On the besis of as | amination end/or i | rivestigatio | n, in my op | olnion, de | ath occur | ed at the | time, de | ta and piece, and | due to th | e cause(a) | and manner as stated. |
| w | 296. SIGNATURE AND TITLE | OF CENTIFIER | 1 | 1 | | | | 29c. LICE | NSE NUM | BER | | | | (Month, Day, Year) |
| TO B | Naw M. | San | sslow. | 100 | | | | 01 | 794 | 47 | | Au | gust | 31,1995 |
| - 1 | 30. NAME AND ADDRESS OF | PERSON WH | - / | | | | | | | | | | | ,MD20852 |
| | C | | | | | | | | | were. | - | . 1 | | |

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | HEGISTHAN | | | | CERTIF | ICAI | E UF | DEATH | | REG. NO | | | |
|---------------|------------------------------------------------------------------------------------|-------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------|----------------|-------------------|------------|--------------------------------|-------------|-----------------|------------------------------------|
| , | DEDNADD MICHARI MONTH DAY YEAR | | | | | | | | | | | | S 20 A |
| - 1 | 4. SOCIAL SECURITY NUM | s. last birthday) | = IMOS | R 1 YEAR | IF UNDER 24 HRS. | 36 | PL J, | 1777 | | | | | |
| | 579-40-884 | 4 | 1 🔀 📈 2 🗆 F | | 7 1 YRS. | MONTHS | T | HOURS MIN. | | | 1924 | Country) Peni | ace (State or Foreign asylvania |
| . | 9a. FACILITY NAME (If not | | | | | | | OR LOCATION OF | | | | TY OF DEA | |
| CTOR | 110 Claybr | | | | | 3 | TIVE | r Spring | 5 | | Mon | tgome | ery |
| | 10a. STATE | 10b. COUNT | 7 | | 10c, CIT | Y, TOWN | OR LOCAT | TION | | | | 1 | Od. INSIDE CITY |
| } | Maryland | Mon | tgomery | Si | lver | Spr | ing | | | | - 2 | LIMITS? | |
| | 10e. STREET AND NUMBER | 4 | | | | | 10 | f. ZIP CODE | | | 10g. CITIZ | EN OF WH | AT COUNTRY? |
| FUNERAL | 110 Claybr | ook Dr | ive | | | _ 1 | 20902 | | | U. | S. A | Α. | |
| | 11. MARITAL STATUS 1 Never Married XX | K | 12. WAS DECEDENT E | VER IN U.S | S. ARMED | 13. | WAS DEC | CENDENT OF HISP | ANIC ORIG | IN? (Specify Yes | or No- | 14. RACE - | - American Indian, White, atc. |
| | 3 Widowed 4 Div | | IF YES, GIVE WAR | OR DATES | | | | 2XXNO Spec | | recent, with | | Whit | |
| 3 | | CEDENT'S EDU | | 164 | Give kind of | work done | during mo | ON ost of working | 16 | b. KIND OF BU | SINESS/INDU | JSTRY | |
| | Elementary/Secondary | | College (1-4 or 5+) | | life. Do NOT us | se retired.) | | | | | 0 | | |
| | 17. FATHER'S NAME (First, I | | Years | P | ublic . | Admi | nışt | | | U.S. | _ | nmeni | C . |
| COMPL | Max Michae | | | | | | | ta. MOTHER'S N | | | Sumame) | | |
| 4 | 19a. INFORMANT'S NAME (| | - | | Eros aron mo | | | Sylvia | | | | | |
| 2 | Muriel N. | are selling | | | | nd Number or Aura Drive, | | | | | 20902 | | |
| | 20a. METHOD OF DISPOSIT | on 3 Ram | oval from State | ceandbate of Disposition (Name of Sept. 4.5) cremetory or other place) ropolitan Crematory 1995 Alexandria, Virginia | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | , V1 | rginia |
| 1 | · Done | rld (| State | Zem | yer | S | TEIN | HEBREW | MEMO | RIAL F | UNERA | L HON | ME, INC. GTON, D.C. |
| | 23. PART I. Enter tha d | diseases, or o | complications that c | aused the | death. Do r | | r the mo | de of dying, su | ch aa ca | diec or reap | ratory arre | at, | Approximate |
| | ahock, or heart fallure. List only one cause on each lina. IMMEDIATE CAUSE (Finel | | | | | | | | | | | Onset and Death | |
| | disease or condition resulting in death) | LAL | CANCLA | | UEAR | | | | | | | | |
| ŀ | | | DUE TO (OF | F): | | | - | 1 | | | | | |
| 5 | Sequentielly list condi- | tiona. | b | | | | | | | | | | |
| | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | |
| 2 | CAUSE (Disease or Injuthat Initiated events | | OUE TO (OF | R AS A COR | NSEQUENCE OF | n: | | | | | | | |
| CERTIFICATION | resulting in deeth) LAS | ST | | | | , | | | | | | | |
| - 19 | - | | | | | | | | | | | | + |
| EDICAL | PART II. Other algolific | | | | | | | | Part I. | 24e. WAS AN PERFOR | | | ERE AUTOPSY FINDINGS |
| ś II | CONGLET | ; INTE. | STIN | AL | | | 1 TYES 2 | KNO | C | OMPLETION OF CAUSE F DEATH? | | | |
| Σ | OBSTRUCTI | البه | | | | | | | | ľ | | 1 | YES 2 NO |
| ž I | DID TOBACCO U | | RIBUTE TO CAUS | SE OF D | EATH YE | S 🗆 | NO K | UNCERTA | IN 🗆 | | | | |
| HYSICIAN | 25. WAS CASE REFERRED 1 EXAMINER? | TO MEDICAL | HOSPITAL: | 26. F | PLACE OF DEAT | OTHE | | | | | | | |
| 2 | 1 TES 2 NO | | 1 Inpatient 2 E | _ | M 3 DOA | | | e 5 Residence | 6 🗆 Oth | er (Specify) | | | |
| E | 27. MANNER OF DEATH | Pending | 28a. DATE OF INJ (Month, Day, | | 26b. TIM INJ | URY | 28c. INJ WO | URY AT | 28d. DE | SCRIBE HOW I | NJURY OCCI | JRED | |
| 5 | 2 Accident | | М | | YES 2 NO | | | | | | | | |
| 9 | 3 Suicide 8 Homicide | street, Inc | tory, office | • | 281. LO: | CATION (Street a or Town, State) | nd Number o | or Rural Rou | te Number, | | | | |
| | AA- CERTIFIED | | | | | | | | | | | | |
| | (Check only | | CIAN: To the best of my R: On the basis of exam | | | | | | | | | | nd menner as stated. |
| 3 | 291 SIGNATURE AND TITLE | | | | | | | 29c. LICENSE NL | | | | | fonth, Day, Year) |
| | Martina | 8hens | (2 2 | | | | - 1 | 2089 | LL | | DATE | - 4 | L 1995 |
| 2 | 30. NAME AND ADDRESS O | F PERSON NO | COMPLETEO CAUSE | OF DEATH | (FTEM 27) (Type, | Print) | | 275- /5 | 200 | 40 4 | 0. | 21/ | 1 7 7 7 |
| | MANTIN C. | SHA | | | | | | 3720 F | CT | MOUS D | 7 4 | 0 - | |
| | 31. DATE FILED (Month, Day. | Year) | 32. REGISTRAR'S | SIGNATUR | RE | | | . 50,00 | V~1 0,U | no | 000 | 70 | |
| II. | SEP 0 81 | 995 | usa dividese | Mark | 11 | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

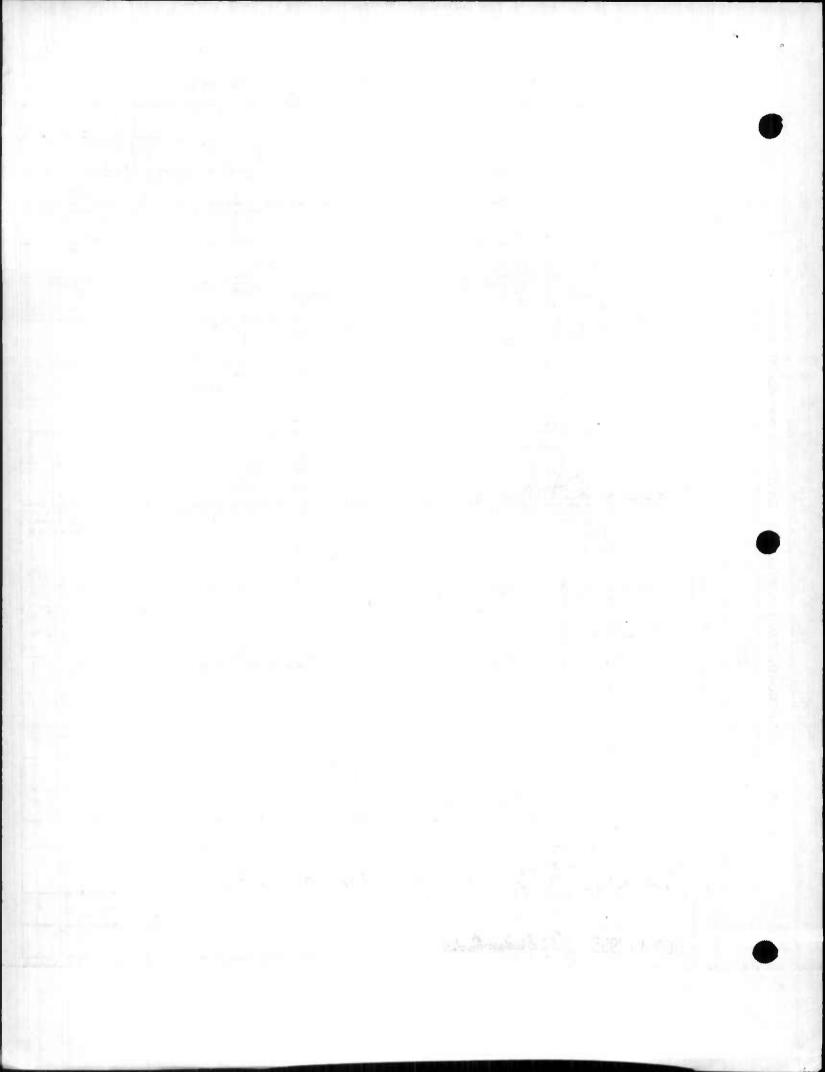
FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| HEGISTHAH | | | C | Entire | CALE | UF | DEAL | п | | HEG. NO | | | |
|-------------------------------------------------------------------------|---------------------------------------|--------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------|--------------|-------------------------------------|----------------------------|-----------------------------|-------------------------|-----------------------------------------------------------|----------------------------------------------------------------------|
| 1. DECEDENT'S NAME (FIN | | Nelson | | | | | | | 2. DATE 0 MONTH Sept | D | 995 | YEAR | 3. TIME OF DEATH 9,30A |
| 4. SOCIAL SECURITY NUI | | 5. SEX 6 | AGE (In yrs. le | st birthday) YRS. | IF UNDER 1 | YEAR DAYS | HOURS | MIN. | 7. DATE OF (Month). Feb. | Day, Ybar) | 923 | Coun | HPLACE (State or Foreign try) nnsylvania |
| 9a. FACILITY NAME (If not | Institution, give | street and number) | | | 9b. CITY, 1 | OWN OF | LOCATIO | N OF DE | | | | INTY OF I | |
| 303 Edgev | | Drive | | | Edg | gewa | ater | | | | Anne | e Aı | rundel |
| RESIDENCE OF DE | 10b. COUNT | Υ | | 10c. CIT | Y, TOWN OR | LOCATI | ON | | | | | | 10d, INSIDE CITY |
| MD | Anne | Arundel | | | | jewa | ater | Dr | rive, | Edg | | | LIMITS? |
| 303 Edges | | Drive | | 101. ZIP CODE 21037 | | | | | | | | SA | WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Alever Married 2 3 Widowed 4 Di | | EVER IN U.S. AI YES 2 X | | 11 | yes, spe | | , Mexica | NIC ORIGIN? un, Puerlo Rid y: | | a or No— | t4. RAC Blac Spec | E - American Indian, sk, White, etc. city: White | |
| | ECEDENT'S EDU | | 16a. D | ECEDENT'S | USUAL OCC | CUPATIO | N . | | 16b. I | IND OF BU | ISINESS/IN | DUSTRY | |
| Elementary/Secondary | (0-12) | College (1-4 or 5+) | Si fi | Give kind of v le. Do NOT us Dervi | se retired.) | inng mos | t or working | , | | Sim | nula | tors | 5 |
| 17. FATHER'S NAME (First, | Middle, Last) | | - | | | | 18. MOTH | ER'S NA | ME (First, Mi | | | | |
| Daniel Ma | | Veary | | | | | | | Marth | | | | |
| 19a. INFORMANT'S NAME | | | | | | | | | Floute Numbe | | | | |
| John Lesi | lie Ne | elson | 3 | 303 E | Edgev | vate | er D | r. | Edge | wate | er, 1 | MD 2 | 21037 |
| 20a, METHOD OF DISPOS 1- Burlal 2 Crema 4 Donation 5 Oth | ITION tion 3 - Ran er (Specify) | noval from Stata | cametery cr | AND DATE OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMME | ther place) | | | | 9/6 | | | | own, Stata |
| 21. SIGNATURE OF FUNE | RAL SERVICE L | CENSEE | 1 - 1 | 0 | 22. N | AME AN | DADDRES | S OF FA | | | | | |
| 23. PART I. Enter the shock, or | | complications that | | | | | | | | | | | Approximate Interval Batwee |
| IMMEDIATE CAUSE (I disesse or condition resulting in death) | Finsl | BA | Bew | er | + | | | | | | | | Onest and Das |
| | | DUE TO (C | OR AS A CONSI | EOUENCE O | F): | | | | | | | | |
| Sequentially list cond | | b. DUE TO (C | OR AS A CONSI | EQUENCE O | Pi: | | | | | | | | |
| if any, leading to imm cause. Entar UNDERI | | | | | | | | | | | | | |
| CAUSE (Disease or in that initiated events resulting in death) L/ | | DUE TO (C | OR AS A CONS | EQUENCE O | F): | | | | | | | | |
| | | d | | | | | | | | | | | |
| PART II. Other significant | cant conditio | ons contributing to d | eath but not | resulting | In the unc | ierlying | cause g | ilven in | | PERFO | RMED? | 24 | b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | I [] TES | 2 4 4 10 | | OF DEATH? |
| DID TOBACCO | USE CON | TRIBUTE TO CAU | SE OF DE | ATH YE | SON | 10 🗆 | UNC | ERTAI | NO | | | | |
| 25. WAS CASE REFERRED | | | | ACE OF DEA | | | | | | | 17 | | |
| EXAMINER? | | HOSPITAL: | ER/Outpetient | 3 DOA | OTHER 4 Nursi | : ing Home | 5 Fi Ra | aldence | 6 Other | (Specify) | | | |
| | Pending Investigation | 26a, DATE OF II (Month, Day | | 28b. TIN | IE OF JURY M | 28c. INJI WO | |] NO | 28d. DE\$6 | RIBE HOW | INJURY O | CCURED | |
| 2 Accident 3 Suicide 6 (| Could not be determined | 26s. PLACE OF | INJURY — At I | home, tarm, | street, facto | ry, office | | | 261. LOCA City o | TION (Street Town, State | and Numb | er or Rura | Route Number, |
| Torribon ormy | | SICIAN: To the best of ri | | | | | | | | | | | (a) and manner as stated. |
| 29b. SIGNATURE AND TO | Sille | ER | | | | | 29c. LICE | 070 | 18 | | 1 4 | TE SIGNE | ED (Month, Day, Year) |
| 30. NAME AND ADDRESS | OF PERSON W | | of DEATH (IT | EN 27) (Type | Print) | Leu | ional | 'es | Ms | 214 | 61 | | |
| 31. DATE FILED (Month, D. | | 32. REGISTRAR | 'S SIGNATURE | | , ,, | | 9 | | | | | | |
| I SEP | 8 199 | 5 Jahrada | nation V | ordalf. | | | | | | | | | |

| BALTIMORE, MARYLAND 21215-0020 | death. Page 6 may be retained by the hospital or attending physici | the second section and the second section is the second section of the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the second section is the second section in the second section in the section is the second section in the second section in the section is the second section in the section is the section in the section is the section in the section in the section in the section in the section is the section in the section is the section in the section in the section in the section is the section in the section is the section in the section in the section in the section is the section in the section in the section in the section in the section is the section in the section in the section in the |
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| | hours after | lad in he she |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physici | DARWING MAN MAN MAN MAN MAN MAN MAN MAN MAN MAN |
| S | TTEND | a .out |

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | remation, or removal. | ent, the medical examiner must be notified at once. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician | be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| 1 - STATE REGISTRAR | | | TE OF DEAT | | AL HYGIENE REG. NO. | | |
|----------------------------------------------------------------|-----------------------------------|---------------------------------------------------------|----------------------------------------------|-----------------------------|-------------------------------------|----------------|------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Las | 00) | | | 2. DAT | TE OF DEATH | YEAR | 3. TIME OF DEATH |
| Bertie 4. SOCIAL SECURITY NUMBER | Mae 5. SEX 6. AGE | Newton (In yrs. last birthday) | | | | 995 | 8:50 A. |
| | | MON | MOER 1 YEAR IF UNDER 2 THE DAYS HOURS | | E OF BIRTH rith, Day, Year) | 8. BIRT | HPLACE (State or Foreign try) |
| 315 24 2548 90. FACILITY NAME (If not institution, give | * ' | 33 | CITY, TOWN OR LOCATION | | r 24 1912 | OUNTY OF | ntucky |
| 25120 Seneca Via | | | aithersbur | | | ontgo | |
| 10e. STATE 10b. COU | | | WN OR LOCATION | | | | 10d. INSIDE CITY |
| 11012) = 0.00 | ntgomery | Gaith | ersburg | | | | 1 X YES 2 NO |
| 100. STREET AND NUMBER 25120 Seneca Vie | ew Court | | 101. ZIP CODE | 82 - 3616 | | CITIZEN OF US | WHAT COUNTRY? |
| 11, MARITAL STATUS | 12. WAS DECEDENT EVER | IN II S ARMED | 13. WAS DECENDENT OF | | | | E — American Indian, |
| 1 Never Married 2 Married | FORCES? 1 TYES | XXX NO | If yes, specify Cuben, | Maxicen, Puert | | Blec | ck, white, etc. |
| 15. OECEDENT'S E (Specify only highest gro | DUCATION ade completed) | 16a. DECEDENT'S USU | AL OCCUPATION done during most of working | 10 | 66. KIND OF SUSINESS | INDUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Itle. Do NOT use ret | red.) | | G | | , |
| 12 | | Dog w | larden | | State of 1 | Kentu | ску |
| 17. FATHER'S NAME (First, Middle, Lest) | Ranzy Fulks | | | er's NAME (First oda McW | , Middle, Maiden Sumem laters | •) | |
| 190. INFORMANT'S NAME (Type/Print) Margaret N. Hari | ich | | RESS (Street end Number of item 10a- | | mber, City or Town, State, | Zip Code) | |
| - | | | | | Tax according | | 530 Hills |
| 20a. METHOD OF DISPOSITION 1. Burlel 2 Cremetion 3 | cer | b. PLACE AND DATE OF DI metery, crematory or other p | | 1 | TE 20c. LOCATION | | |
| 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE | Accounter 1 | aple Grove | Cemetery 22. NAME AND ADDRESS | 19/ | 7 Fairde | aling | . Kentucky |
| | | / | | | eral Homes | 2 | |
| 23. PART I. Enter the diseases, of | Mean | ou- | 2847 Wilso | on_Blvd | Arlington | a. VA | 22201 |
| IMMEDIATE CAUSE Final disease or condition resulting in death) | a. Cardio Pu DUE TO (OR AS | 1monary Fa | ilure | | | | Interval Batwe Onset and De |
| Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| CAUSE (Disease or Injury | End Stage Alzheimer's | | | | | | |
| that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| reaulting in death) LAST | d | | | | | | |
| PART II. Other algnificant condit | one contributing to death i | but not resulting in th | e underiving cause gi | ven in Part I. | 24a. WAS AN AUTOP | SY 24 | b. WERE AUTOPSY FINDIN |
| | | | | | PERFORMED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | 1 TYES 2 NO | | OF DEATH? |
| | | | | | | | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 02 Pt 405 05 05 | ATH COLUMN | | | |
| EXAMINER? 1 YES 2 NO | HOSPITAL: | | 26. PLACE OF DE. HER: | | | | |
| 27. MANNER OF DEATH | 1 Inpetient 2 ER/Out | 26b. TIME OF | Nursing Home 5 X Res 28c, INJURY AT | 7 | her (Specify) ESCRIBE HOW INJURY | OCCUBED | |
| 1 Natural 6 Pending | (Month, Day, Year) | INJURY | WORK? M 1 YES 2 | | ESCHIBE HOW INJUNT | OCCORED | |
| 2 Accident Investigatio | 26. DI ACE OF IN HIE | Y — At home, ferm, street | | | OCATION (Street and Num | nher or Prival | Boute Number |
| 4 Homicide 8 Could not a | building, atc. (Spi | icify) | ,, | Ci | ty or Town, State) | noer or more: | riodia raprioar, |
| 29a, CERTIFIER DY | | | | | | | |
| | YSICIAN: To the best of my know | | | | | | |
| 4 | INER: On the basis of axamination | on endor investigation, in | my opinion, death occure | α πιο τίπιο, da | ne and place, end due t | o The Cause | (s) end menner as stated |
| 296 SIGNATURE AND TUTLE OF CENTS | 571. 1 | | 29c. LICEN | SE NUMBER | / 29d. (| DATE SIGNE | D (Month, Day, Year) |
| anny | 1 Buds | ules | 103 | 123 | 60 | Augus | t 31, 1995 |
| SE HAME AND ADDRESS OF PERSON | | | | #200 | Do al: 11 | Man | 1 on J |
| Carolyn B. Hendi | | | enter Drive | # 300 | KOCKA1TT6 | , mar | yland |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGI | NATURE | | | | | |
| SEP 0 81995 Ju | in a water had | AL. | | | | | |



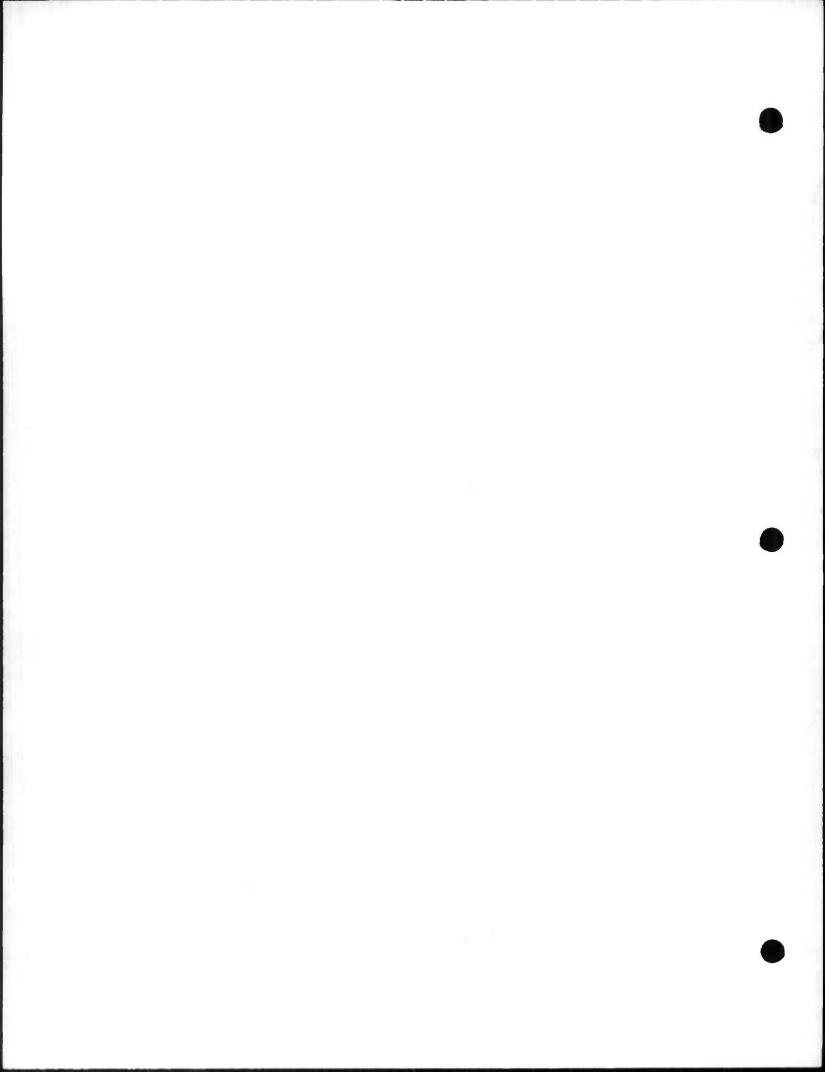
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | HEGISTHAN | | | | CER | TITIO | AIE | OF I | DEMI | п | | HEG. NO | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------|------------------------------|-------------------------------|-------------|--------------|-------------------|-------------|-----------|---------------|-------------------------------------------------------------------------|-------------|---------------------|--------------------------------------------------|
| | 1. DECEDENT'S NAME (First | | | | | | | | | | 2. DATE (| Di | W | YEAR | 3. TIME OF OEATN |
| | KA I | HARINE | | PARKS | | | | | | | | nber 6, | 1995 | | 7:25P M |
| | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | SEM | 5. SEX 1 M 2 XXF | 6. AGE (In) | | | NTHS DA | | IF UNDER | MIN. | | Day, Year) | | 8. BIRTN Country | PLACE (State or Foreign |
| | 228-40-9669 90. FACILITY NAME (If not in | estitution also e | 701 | 93 | | 200 | a. CITY, TO | MRI OD | LOCATIO | | | 3, 1902 | | Mary | |
| Œ | Roland Park P | | noon and numbery | | | , , | | - | | JN UP UE | EATH | | | NTY OF O | ATN |
| 25 | RESIDENCE OF DEC | CEDENT | | | | | Balt | TIIDI | е | | | | N/A | 4 | |
| DIRECTOR | Maryland | 106. COUNTY | /A | | 10 B | Balti | MOre | OCATIO | ON | | | | | | 10d. INSIDE CITY LIMITS? 1 [V] YES 2 [] NO |
| AL | 10e, STREET AND NUMBER | | | | | | | 101. 2 | ZIP CODE | | | | 10g. CIT | IZEN OF W | HAT COUNTRY? |
| 띨 | 830 West 4 | Oth St | reet | | | | | 21 | 211 | | | | 1 | USA | |
| 2 | 11. MARITAL STATUS 1 Never Married 2 | Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U. | S. ARMEO |) | 13. WAS | OECEP | NOENT O | F NISPAN | IIC ORIGIN? | (Specify Yes | or No- | 14. RACE Black | - American Indian, White, etc. |
| D BY FUNERAL | 3 Widowed 4 Olvo | rced | IF YES, GIVE V | WAR OR OATE | | | | | | Specify | | | | Specif | |
| COMPLETED | 15. OEC (Specify only | EOENT'S EDU y highest grade | CATION completed) | 16 | 6a. DECEO | ind of work | done durin | PATION og most | of working | g | 16b. | KINO OF BUS | INESS/INC | DUSTRY | |
| ا ڐ | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | +) | | NOT use re | | | | | | | | | |
| 8 | 17. FATNER'S NAME (First, M | licidle (ast) | | | | ecre | tary | _ | 10 MOTH | ED'S NA | ME (First A4) | eddle, Malden | vate | | |
| ၓ၂ | John R. Hu | | | | | | | | ie. moin | | | | | | |
| 8 | 190, INFORMANT'S NAME (7 | | | | 19b. MA | AILING AO | ORESS (St | reet enc | 1 Number | | | rgini | | | |
| 2 | Nancy S. Las | sher | | | | | | | | | | nnsyl | | | 27 |
| | 20e. METHOO OF DISPOSIT | ION | | 20b. PL | LACEANO | OATEOFO | ISPOSITIO | | | NOC | OATE | | | City or Ton | |
| | XIX Buttal 2 Cremetlo 4 Denation 5 Other | (Specify) | oval from Stata | cemete. | Gree | ny or other | plece) | | | | 9/9/ | Bal: | timor | e M | arvland |
| | 21. SQNATURE OF FUNERA | L SERVICE LIC | ENSEE | | 1 | | | AE ANO | ADDRES | S OF FAC | CILITY | | | | |
| | Nonnio D | Ness | Confle | NO | Re | | 650 | 0 Y | ork | Road | d Ral | ell-W timor | - M/ | lryla | Home nd 21212 |
| | 23. PART I. Enter the di ahock, or h | eert failure. | complications the List only one ceu | t caused the | ha death. h iine. | Do not | enter the | moda | a of dyle | ng, auct | h as cardi | ec or respi | ratory an | rest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | | | |
| | resulting in death) | → | | | | - | _ | | | | | | | | |
| | | | OUE TO | (OR-AS A CO | ONSEQUEN | NCE OF): | | | | | | | | | |
| <u></u> | Sequentially list conditi | | b DUE TO | (OR AS A CO | ONSEQUEN | VCE OF): | | | | | | | | | 1 |
| A | if any, leading to imme- cause. Enter UNDERLY | NG | | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or inju that initieted events | | OUE TO | (OR AS A CO | ONSEQUEN | ICE OF): | | | | | | | | | |
| | resulting in death) LAS | T (| d | | | | | | | | | | | | |
| | PART ii. Other aignifice | nt condition | s contributing to | death but | not resul | iting in t | he under | duina e | COLUMN | luna la l | Doct I | 24- 98-241 | ALITODAN | 0.00 | |
| EDICAL | PART II. Other algnificent conditions contributing to death but | | | | in the underlying codes given | | | iren ili | PERFORMEO? | | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | | | | | | | | | | | | 1 YES 2 | X10 | | OF DEATN? |
| Σ | DID TOBACCO U | SE CONITI | DIDLITE TO CA | LISE OF I | DEATH | VEC | | | LINIC | EDTAIN | . 5 | | | | 1 YES 2 NO |
| AN | 25. WAS CASE REFERRED TO | | KIBUTE TO CA | | PLACE OF | | | | UNC | ERTAIN | 1 X | | _ | | |
| PHYSICIAN: | EXAMINER? | | HOSPITAL: | | | O. | THER: | | · // e | WEST. | a [] au | | | | |
| Ē | 27. MANNER OF OEATN | | 28e. OATE OF | INJURY | | b. TIME O | F 280 | . INJUF | TA YE | sidence | 6 Other | RIBE NOW II | JURY OC | CUREO | |
| ВУР | 5000 | Pending Investigation | (Month, D | ay, Ybar) | | INJURY | | WORK | K? S 2 _ | NO NO | | | | | |
| | 2 Distriction — | Could not be | 26s. PLACE O | F INJURY — atc. (Specify) | At home, f | farm, stree | et, factory, | office | | | 28f. LOCAT | FION (Street e | nd Number | or Rural R | oute Number, |
| | | determined | bullany, | аны (арвину) | | | | | | | City or | Town, Stete) | | | |
| 5 1 | 29e. CERTIFIER 1 CERT | IFYING PNYSI | CIAN: To the best of | my knowledg | ge, death o | occurred a | t the time. | date er | nd place. | and due | to the caus | e(e) end man | ner se stat | led. | |
| COMPLEIED | | | | | | | | | | | | | | | end manner es stated. |
| | 29b. SIGNATURE AND TITLE | | | | | | - | | | NSE NUM | | | | | (Month, Day, Year) |
| | W2: | 9~ | MD | | | | | | | -371 | | | • | | ember 7,199 |
| 2 | 30. NAME AND ACCRESS OF | PERSON WH | O COMPLETEO CAU | SE OF OEATN | 1 (ITEM 27) | (Type, Prir | nt) | | <i>D</i> - | 5/ 1. | 00 | | | Sept | chiber /, 19 |
| | Donna | a Dow | 6301 No | rth Ch | narle | s St | reet | Ba | ltin | nore | . Mar | vland | 212 | 12 | |
| | 31. DATE FILEO (Month, Day, | | J 32. REGISTRA | R'S SIGNATU | JRE | | | | | | | , - 3110 | | | |
| | SEP 0 819 | 95 g | ely attended | orhando | 14 | | | | | | | | | | |
| | | 0 | | | | | - | | | | | | | | OHMH. 16 Peu 1/ |



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| . The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REGISTRAR REG. NO 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle 2. DATE OF DEATH SS PISM BER YEAR ispn. HAR 4. SOCIAL SECURITY NUMBER 5. SE) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig IF UNDER 1 YEAR IF UNDER 24 HRS. APRIL 6 DARY! 57 DAYS HOURS 17 M 2 | F 21618 639 YRS. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9e. FACILITY NAME (If not institution, give ROAC ASOT L BALTIMORS DIRECTOR 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARVLAND BALLIMOR ARKVILLS 1 - YES 2 1 NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10. STREET AND NUMBER 101, ZIP CODE 21234 A SOAC 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE --- American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TYES 25 NO Specify: BY 3 Widowed 4 Divorced 子ろうと COMPLETED 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b, KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) 10 YRS. ISAMFIT 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, PROBST HERMAN BE 24234 19e. INFORMANT'S NAME (Type/Print) 2 MARIE [/ARY] 20e. METHOD OF DISPOSITION

Suriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 95 BRY 4 Donetion 5 Other (Specify) 21. SIGNATURE OF PUNETAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY EVANS CHAPLE OF DEC 8800 HARFORD 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, abock, or heart failure. List only one suse on each line. Approximats Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (ONAS A CONSEQUENCE OF) 3 years Cauces CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? COPD 1 TYES 2 NO 1 YES 2 NO YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL **EXAMINER?** 1 YES 27 NO 6 Other (Specify)

Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 52 Reside 28e. DATE OF INJURY (Month, Day, Year) 28d, DESCRIBE HOW INJURY OCCURED

28c. INJURY AT WORK?

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Faun Stells)

29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my

2 MEDICAL EXAMINER: On end due to the ceuse(a) and manner ee stated 29c. LICENSE NUMBER

8 Could not be

determined

27. MANNER OF DEATH

1 Natural

2 Accident

4 Homicide

3 Suicide

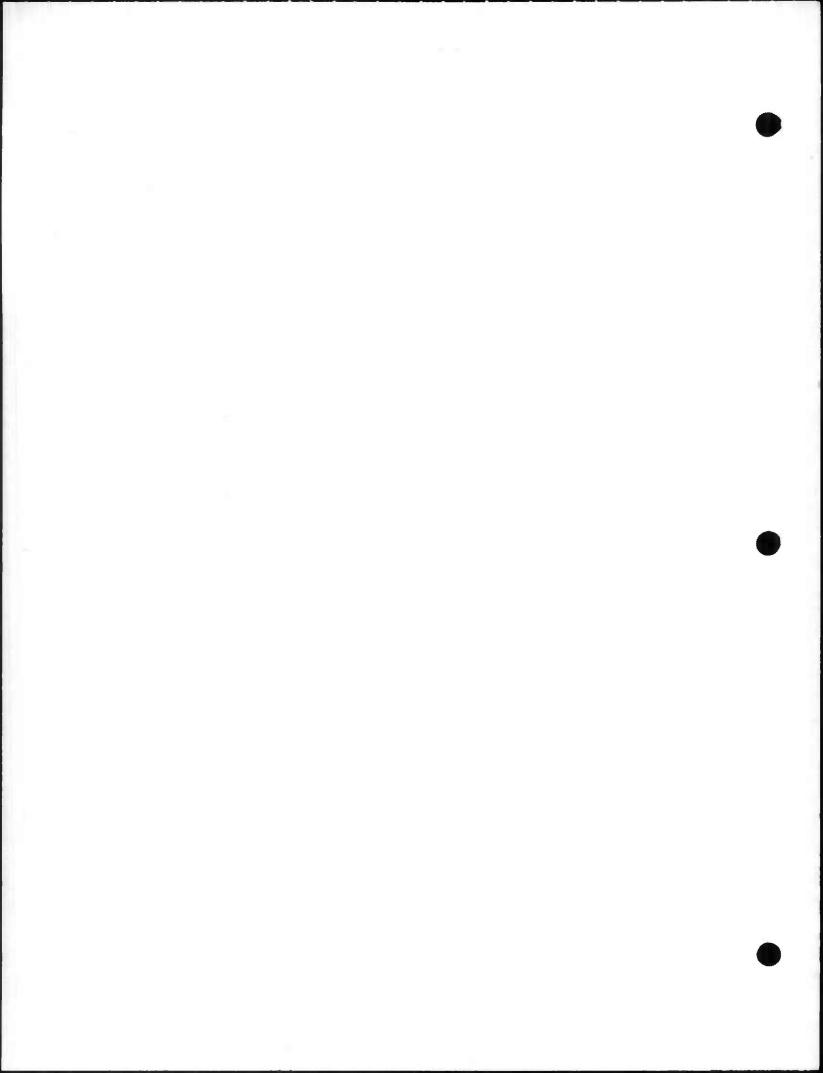
BY

COMPLETED

BE 2 .

1 - FOR STATE REGISTRAR

| | | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | | HYGIENE REG. NO. | | | | | |
|---------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------|---------------------------|--------------------------------|------------|------------------------------------------------------------|------------|--|
| | | 1. OECEDENT'S NAME (First, Middle, Lest) | J. PISTOI | r.as | | | 2. DATE OF MONTH Sept. | DEATH | 1995 | AR | TIME OF O | AM . | |
| Pir | | 4. SOCIAL SECURITY NUMBER 213-60-4055 | 5. SEX 6. AGE (I | n yrs, lest birthday) IF YRS. MO | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, D) 11-2' | BIRTH Day, Year) | 8. 5 | | CE (State o | | |
| . 2, 3 should | TOR | 9a. FACILITY NAME (II not institution, give 1208 Doragen Ct RESIDENCE OF DECEDENT | | 96 | Luther | ville | EATH | | Balti | | | | |
| Pages 1, | DIRECTOR | 10a. STATE 10b. COUNT Maryland Balt: | | | own on Local | | | | | | LIMITS? | | |
| isit permit. | FUNERAL | 10e. STREET AND NUMBER 1208 Doragen Ct | | 1 IIII | | 1. ZIP CODE 21093 | | | 10g. CITIZEN | OF WHAT | YES 2 | 4.6 | |
| 21215-0020 al or attending physician. for use as the burial-transk | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES | | | 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | Specify Year in, etc.) | Black, White, atc. Specify: | | Indian, | | |
| 21215-0 al or attending for use as the | ETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | | 18e. DECEDENT'S USU (Give kind of work life. Do NOT use re | done during mo | ON ost of working | 16b. KI | ND OF BUSI | NESS/INDUST | hite m | | | |
| | COMPLET | 10 yrs 17. FATHER'S NAME (First, Middle, Last) | 10 yrs Homema | | | | aker Own H | | | | | | |
| MARYLAND retained by the hospit s should be detached notified at once. | BE | Zenon Kakot 19a. INFORMANT'S NAME (Type/Print) | ılis | 19b. MAILING AD | ORESS (Street a | Athena | | | ngelou State, Zip Cod | ie) | | | |
| MR, M. may be reta or, page 5 s | 10 | Nicholas J. Pist | 20b. | PLACE AND DATE OF D | SPOSITION (Na | cle Balt | imore | _ | 21093 ATION — City | or Yown, | State | | |
| O S S E | | 1 Serial 2 Cremation 3 Ran 4 Donation 5 Other (Specify) | | etery, crematory or other Greek Orth | 22. NAME A | ND ADDRESS OF FA | 9-6 | | timore | | ryla | nd | |
| BALTIMO hours after death. Page 6 din by the funeral direction removal. medical examiner mu | | 23. PART I. Enter the diseases, or | complications that caused | the death Do not | 1050 | Towson F York Rd. | Tows | on, Mo | 1. 212 | | | | |
| within 24 hours pletely filled in b cremation, or referr, the medi | | shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | a. Meta | consequence of: | | | | | | | | and Deatl | |
| P.O. BOX 687 h certificate be execute anding physician and co Hygiene prior to buria or other traumatic | CERTIFICATION | Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | C | CONSEQUENCE OF): | | | | | | | | | |
| CORD: ires that the signed by the leafth and M ws any Inju | MEDICAL | PART II. Other significent condition | na contributing to death be | ut not resulting in the | ne underlyln | g cause given in | | PERFORM | IED? | CON | RE AUTOPS ILAGLE PRI MPLETION (DEATH? YES 2 [| OF CAUSE | |
| 0 | SICIAN: N | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | | F DEATH YES | | UNCERTAIN | ۷ 🗆 | | | | | | |
| o the cla | PHYSIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inputient 2 ER/Output 280. DATE OF INJURY | | | Ne 5 Residence | | - | JURY OCCURE | D | | | |
| After death death | D BY P | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | (Month, Day, Year) 28e. PLACE OF INJURY | — At home, lerm, stree | M 1 🗆 | PRK? YES 2 NO | | | d Number or Ri | | Number, | | |
| DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma | ETE | 4 Homicide determined | building, etc. (Speci | | | | City or 1 | fown, State) | | | | | |
| 로 경 전 = | COMPL | one) 2 MEDICAL EXAMIN | ICIAN: To the best of my knowle | | | | | | | ise(s) enc | 1 manner 1 | ss stated. | |
| TO THE HOSPI TO THE FUNER be filed within | TO BE | 296. SIGNATURE AND TITLE OF CENTRE | Mhy | The | Z | D25 | | 5 | ▶ 9/ | NED (Mor | oth, Day, Yo |)) | |
| | | Dr. Anthony Ri | ley G.B.M.C. | , | 0 | | | | | | | | |
| 10 | | SEP 08 1995 | S2 REGISTRAR'S SIGNA | Mardall | | | | | | | | | |



| DALLIMORE, MARTLANI | hours after death. Page 6 may be retained by the hos | lled in by the funeral director, page 5 should be detached on seminal | medical examiner must be notified at once. |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DISCOUNCE WITHE DECONDS, F.O. BOA 80700, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache find within 72 hours after death with the State harm of Heath and Mental Homers and in hual remarking or removal | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN | TO THE FUNERAL DIRECTOR: After this certifith he filed within 72 hours after death with the S | IMPORTANT: If item 28 is marked, or |

| | | | | | | | | 9 | Ü | 21294 | |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | | | EALTH AND | MENTAL HYGIE REG. N | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | Julius Re | neld | Pu | ah | , | 2. DATE OF DEATH MONTH SCOTEM | ber5 | 1994 | 3. TIME OF DEATH OF BEATH | |
| | 4. SOCIAL SECURITY NUMBER 220-78-4432 | 1 ← M 2 □ F | yrs. last birthday) 35 YRS. | IF UNDER | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Dey, Year) Dec 10, | L959 | Country) | aryland | |
| TOR | 9a. FACILITY NAME (If not institution, give s Deaton Nursing Co RESIDENCE OF DECEDENT | | | 9b. CITY | | ltimore | | 9c. COUN | N/A | ATN | |
| DIRECTOR | 100. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN C | | ltimore | City | | | 10d. INSIDE CITY XX LIMITS? 1 YES 2 NO | |
| FUNERAL | 10e. STREET AND NUMBER | | | | 101 | . ZIP CODE | | 10g. CITIZ | EN OF WI | IAT COUNTRY? | |
| NE NE | 3804 W. Garrison | AVENUE 12. WAS DECEDENT EVER IN U | I C AGMED | 142 | WMC DEC | 21215 | NIC ORIGIN? (Specify Y | | USA | | |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | 2 NO | | If yes, sp | | in, Puerto Rican, etc.) | es or No— | Black, | - American Indian, White, atc. Black | |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION 1 completed) | 6a. DECEDENT'S | USUAL O | CCUPATIO | ON st of working | 16b. KIND OF B | USINESS/INDL | ISTRY | | |
| COMPLETED | Elementary/Secondary (0-12) | Cottege (1-4 or 5+) | IIIa. Do NOT u | se retired.) Dunds | | | Apar | tment | Comp | lex | |
| BE CO | Julius Pugh | | | | | Shirl | ME (First, Middle, Maide ey M. Stra | aigten | | | |
| 10 | Shirley Pugh | | 3804 | W. C | S (Street o | rson Ave: | Route Number, City or To nue Baltin | wn, State, Zip (Nore, 1 | %d. 2 | 21215 | |
| | 26e. METNOD OF DISPOSITION 1 Description Method Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Descri | oval from State cemete | ery, cremetory or cestern | ther place) | a . | | Ca Ca | ocation – c atonsv: | 1776 | Mamyland | |
| | 21. SIGNATURE OF CUMERAL SERVICE LIE |)3. Gel | _ | 22. 5 | 502 | Winner | Caple F Ave. Balti | more, | Mary | rvice yland 21215 | |
| | 2) PART Enter the diseases, or shock, or heart fellure. | complications that caused t List only one cause on esc | he deeth. Do | not enter | the mo | de of dying, suc | h as cardiac or res | piratory srre | st, | Approximate Interval Between | |
| | iMMEDIATE CAUSE (Finel disease or condition resulting in desth) | . HIV | DISEGS | P | (+ | 41D5) | | | | Onset and Death | |
| LION | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | |
| CERTIFICATION | ceuse. Enter UNDERLYING CAUSE (Disesse or Injury thet initisted evente resulting in deeth) LAST | C. DUE TO (OR AS A C | ONSEQUENCE O | F): | | | | | | | |
| 55 | | d | | | | | | | | - | |
| | PART II. Other significant condition | s contributing to death but | not resulting | In the un | derlying | ceuse given in | Part I. 24a. WAS A | N AUTOPSY PRMED? | | VERE AUTOPSY FINDINGS | |
| MEDICAL | Cryptaceccal Am | meningits | 1 263 | me | DIL | note | 1 □ YES | 2 No | | WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| Σ | | | | | 10.5 | b | | | 1 | TES 2 10 | |
| AN | DID TOBACCO USE CONTI | | PLACE OF DEA | | | UNCERTAIL | <u>и </u> | | | | |
| 잃 | EXAMINER? | HOSPITAL: | | OTHER | ₹: | | | | | | |
| PHYSICIAN: | | | | | | | | | | | |
| ED BY | 2 Accident Investigation 3 Suicide 8 Could not be determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined determined deter | | | | | | | ute Number, | | | |
| COMPLET | 20. CERTIFIED | CIAN: To the best of my knowled | lge, death occurr | ed at the ti | lme, data | and place, and due | to the cause(s) and m | onner ag state | 1, | | |
| COM | one) 2 MEDICAL EXAMINE | R: On the basis of examination a | | | | eath occured at the | time, date and place, a | | | and manner ea stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | 205 | | | | D 18 99 | | 29d. DATE | SIGNED (| Month, Day, Year) | |
| Ĕ | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED OLUME OF DEATH | | | _ | | | | | | |

LAUREL LAUREL

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9/81
PRITOM S SAIM! MD SEP 0 81995

20节

MD

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S . 744

| hours after death. Page 6 may be retained by the hosp | ed in by the funeral director, page 5 should be detached or removal. | , the medical examiner must be notified at once. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached an entering 20 hours after death with the State heart, or hearth and Mental Homisen prior to burial, crimination, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The Is | TO THE FUNERAL DIRECTOR: After this certificate has be find within 72 hours after death with the State De | IMPORTANT: If item 28 is marked, or item 2 |

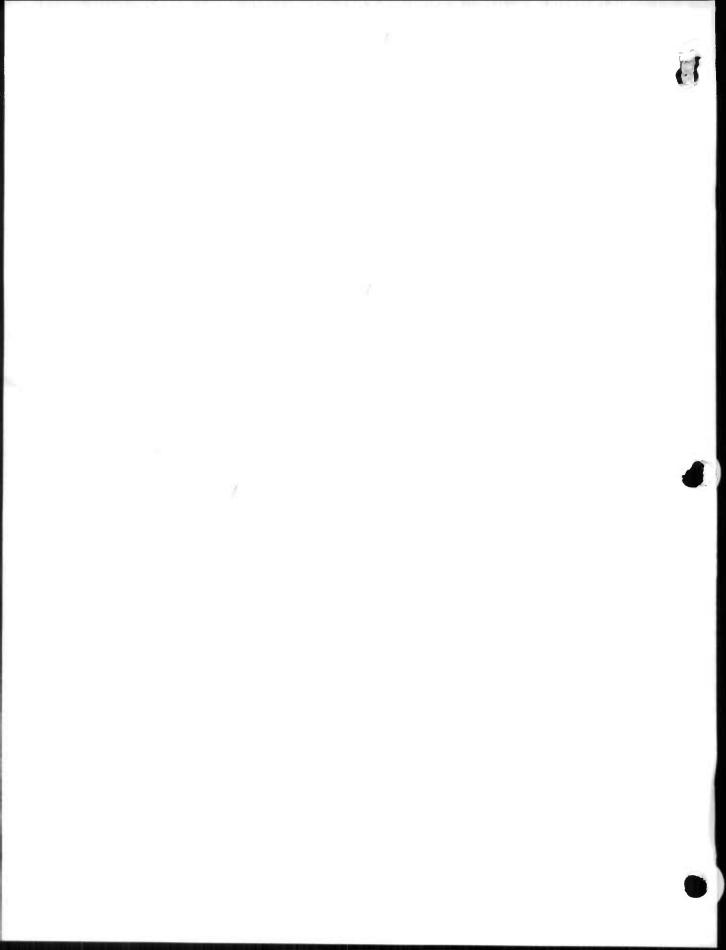
| 1 | FOR STATE REGISTI | IAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. |
|---|-------------------------|---------------------------|------------------------------------------------|----------------------------|
| F | 1 DECEDENTS | MAME (First Middle I not) | | 2 DATE OF DEATH |

| 1. DECEDENT'S NAME (First, Middle, Last | | | | | | 2. DATE MONTH | D/ | AV V | RABY | 3. TIME O | |
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| LINDA A | PEC | rens | | | | SER | | 3 9 | | 080 | 5 |
| 4. SOCIAL SECURITY NUMBER | S. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | 7. DATE (| OF BIRTH , Day, Year) | 8. BIFTNP Country | | v) | te or Foreign | | |
| 202-46-6589 Ba. FACILITY NAME (If not institution, give | 39 | YRS. | | R LOCATION OF E | May 31,1956 | | | Peni | nsylv | ania | |
| University Hosp | | | Baltimore | | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT 10a, STATE 10b, COUN | iTY | | 10c, CITY, TOW | N OR LOCATI | ION | | | | | 10d, INSIC | E CITY |
| Pennsylvania Cumberland | | | | Hill | ~~ | | | | | LIMIT | 2 XNO |
| 1317 Mallard Ro | ā. | | | | ZIP CODE | | | U.S.A | | WNAT COUN | ITRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | VER IN U.S. ARI YES 2 XN OR DATES | | If yes, spe | ENDENT OF NISP/ ocity Cuban, Maxic 2 X NO Spec | en, Puerto F | | | 4. RACI Black Spec Vhit | - Americ k, While, at lly: | en Indian, | |
| 15. DECEDENT'S EC (Specify only highest gra | DUCATION de completed) | (Gr | CEDENT'S USUAL | ne during mos | | 16b. | KIND OF BU | SINESS/INDU | STRY | | |
| Elementary/Secondary (0-12) 12 yrs | //Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired.) | | | | | | Own H | iame | | | |
| 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) Leon R. Ziegler Marie A. Russ | | | | | | | | | | | ALLW |
| Leon R. Ziegler | | 101 | MAILING ADDR | FSS /Simo | nd Number or Rura | | | un State Zie C | Contel | | |
| Cocklin Funeral | Uomo | | | | t St. Di | | | | | | |
| 20a. METHOD OF DISPOSITION | TOTE | - | AND DATE OF DISE | | | LILSDU | | CATION - CH | | warn State | |
| 1 Buriel 2 Cremation 3 TRe 4 Donation 5 Other (Specify) | movel from State | cemetery, cres | matory or other pla | ice) | | 1 | | | | , Guita | |
| 21. SIGNATURE OF SUMERAL, SERVICE | | Hersne | ev Ceme | CETY (| D ADDRESS OF F | ACILITY | Her | shey, | PA | | |
| | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | | | | |
| 23. PART I. Enter the diseases, D ahock, or heart feilur IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. List only one cause | DO NACONSECUTION OF AS A CONSECUTION OF A CONSECUTION OF AS A CONSECUTION OF AS A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A C | ath. Do not en | | | ch as care | | | | Inte | proximate gryal Between and De |
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| | 1. DECEDENT'S NAME (FOIL MICHAEL LOV) 2. DATE OF DEATH SOUTH DAY YEAR 1. THE OF DEATH SOUTH DAY YEAR 1. THE OF DEATH SOUTH DAY YEAR 1. THE OF DEATH | | | | | | | | | | | |
| | 1 Security Number 0. 889 0. AGE (by yrs hall broady) 9 INDER 1 TEAR F. UNDER 50 HIR. 1. DATE OF BUTTIN (NOTICE) DOLL 1987 OCCUPY OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS OF TOOLS | | | | | | | | | | | |
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| DIRECTOR | TOWER I () NO | | | | | | | | | | | |
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| ¥ | 15. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ASMED FORCES 1 VES 2 NO 15. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 2 NO 16. Puer Maritad Glown, etc.) 17. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 2 NO 18. Puerto Glown, Maridean, Puerto Glown, etc.) 18. RACE — American Indian, Specify: 19. WAS DECEDENT (For Indian), Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 2 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FORCES 1 VES 3 NO Specify: 19. WAS DECEDENT (FOR IN U.S. ASMED FOR | | | | | | | | | |
| COMPLETED | 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Element grade completed) Element grade completed Element grade completed Office And of a local devised working most of working Pe. (Por NOI use refered) | | | | | | | | | | | |
| | 17, FATHER'S NAME (First, Missin, Lay) | | | | | | | | | | | |
| TO BE | THE AFFORMANT'S NAME (PROPRIETO) THE AFFORMANT'S NAME (PROPRIETO) White MAILING ADDRESS (FRINGS and Number or Pural Route Number, City or Bland, Sinks 24 Coch) LONE KUSSEL (4822 Co. AVE Balto, Ind 21207) | | | | | | | | | | | |
| | Res. METHOD OF DISPOSITION A Burlai 2 Cremetion 3 Removal from State Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) Denotion 5 Other (Sneety) | | | | | | | | | | | |
| | 11. BIGHATURE OF FUNERAL DETRICE LICENSEE 12. MANG AND ADDRESS OF FACILITY March F. H West 430 & Wabash Ave 430 & Wabash Ave | | | | | | | | | | | |
| | 23. PART I. Error the disease, or complications that caused the death, Do not enter the mode of dying, such se cardiac or respiratory errest, interval Betwoek, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or respiratory errest, interval Betwoek or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or cardiac or car | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, loading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| EDICAL O | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. See, WAS AN AUTOPSY FINDS AND AND TO COMPLETION OF CAUSE OF COMPLETION OF CAUSE OF CEATH | | | | | | | | | | | |
| Σ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO PROPRIATE OT PRET: 4 Norther force only and OT PRET: 4 Norther force F Residence S Other (Specify) | | | | | | | | | | | |
| BY PH | 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day: Near) 20. Time Of INJURY AT WORK? 1 YES 2 NO | | | | | | | | | | | |
| | 3 Suicide e Covid not be determined 80e. FLACE OF INJURY — At home, form, street, factory, office building, etc. (Specify) 101. LOCATION (Street and Number or Rural Repres Number City or Rent, State) | | | | | | | | | | | |
| COMPLETED | OBS. CERTIFIER (Check only CERTIFIER) (Check only MEDICAL EXAMINER: On the basis of axemination and/or investigation, in my opinion, digith occurred at the time, date and place, and due to the cause(s) and menner as stated one) 7 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, digith occurred at the time, date and place, and due to the cause(s) and menner as stated | | | | | | | | | | | |
| OBEC | 280 BIGNATURE AND TITLE OF CENTIFIER 38c. LICENSE HUMBER D 408 54 P 1 195 | | | | | | | | | | | |
| | Doud Ciscley MD 407-T 301 St Part Pl Boldower 21202 | | | | | | | | | | | |
| | 21, DATE PILED (MONTH), Disc. 1907 22, TEGISTRAN'S SIGNATURE | | | | | | | | | | | |



YEAR

995

10g. CITIZEN OF

Specify.

BL

3. TIME OF DEATH

10d. INSIDE CITY 1 YES 2 NO

Approximate

Interval Between

Onset and Death

45 mins

Ye ws

WHAT COUNTRY?

01:03A

Page 6 may be retained by the hospital or attending physician, BALTIMORE, MARYLAND 21215-0020

the funeral director, page 5 should be detached for use as the burial-transit

notified at once. BE

9

must

medical examiner

the

event,

other traumatic CERTIFICATION

0 Injury,

shows any

23

Item State

marked,

99

Dept.

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with

death

hours after 28

TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2

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2

DIRECTOR: After this certificate

PHYSICIAN: MEDICAL

BY

4 Homicide

COMPLETED

BE

2

has been signed by the attending physician and completely filled in by . Dept. of Health and Mental Hygiene prior to burial, cremation, or remo

permit. Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

9

| 3ALT | r death. |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | ATTENDING PHYSICIAN; The |
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| | HOSPITAL |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH JOHNNIE MAE REVELI SEPTEMBER 4. SOCIAL SECURITY NUMBER lest birthday 5. SE) 7. DATE OF BIRTH (Month, Day, Year) DAYS 1 M 2 Z TOWN OR LOCATION OF DEATH RESIDENCE 10a STATE 10b COUNTY TOWN OR LOCATION STREET AND NUMBER 10f. ZIP CODE U.S. ARM MARITAL STATUS AS DECEDENT EVER IN U.S. DRCES? 1 YES 2 YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No It yes, specify Cyban, Maxican, Puerto Rican, etc.)
 U YES 2 NO Specify: 1 Never Married 2 Married FORCES? 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Op NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) 19h. MAILING ADDRESS (St METHOD OF DISPOSITION 6 🗆 complications that ceused the daeth. Do not enter the mode of dying, art failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease of sondition . Intractable Ventricular arrhythmia resulting in death)

DUE TO (OR ANA CONSEQUENCE OF): a Acute Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING SCUD CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension

DUE TO (OR AS A CONSEQUENCE OF)

24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 200 1 YES 2 NO

DIABETES MELLITUS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO

OTHER: 1 - Inpetient 2 - ER/Outpetient 3/S-DOA ng Home 5 - Realdence 8 - Other (Specify) 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

27. MANNER OF DEATH Naturel Investigation 2 Accident 3 Suicide 6 Could not be

26e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 YES 2 NO

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one)

2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

| ١ | -110 | esor | ne | VEL | VMM, | 00 | nnes | |
|---|--------|----------|--------|-----------|------------|---------|----------------|-------------------|
| | NAME A | ND ADDRI | ESS OF | PERSON WH | O COMPLÉTE | D CAUSE | OP DEATH (ITEM | 27) (Type, Print) |

Rome I. Snyder 900 S. CATON AVE, BALTO MD m.D. 21229

32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) 81995

DHMH-18 Ray 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. DEGISTRAR'S SIGNATURE

J. Biddison, M.D.,
31. DATE FILED (Month, Day, Year)
SEP 0 81995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| ITEM: 29d, PER | DR. FIL | M G-728 1 | 0/5/9 | 5 t.t | | | | | | | | U | In I has J U |
|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------|---------------------------|---------------------------------|------------------|------------|-----------------------|------------------|---------------------------------|-------------|-----------------|-------------------------------------------|
| FOR 1 - STATE REGISTRAR | | STATE OF I | MARYL | | EPARTM TIFICA | | | | MENTA | L HYGIE | | | |
| 1, DECEDENT'S NAME (First, | Middle, Last) | | | 02.1 | 1111107 | 1120 | | 3111 | 2. DATE | OF DEATH | J | | 3. TIME OF DEATH |
| Fran | ncis X | Kavier : | Rose | nbrocl | k | | | | MONT | THE | DAY | YEAR | |
| 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (| (In yrs. lest bin | tholou) IF I | JNDER 1 YEA | | DER 24 HRS. | Ser | OF BIRTH | 199 | | HPLACE (State or Foreign |
| 218-03-6012 | 2 | 1 🔀 M 2 🗌 F | | | YRS. MON | | | | | th, Day, Year) | 1019 | Count | RYLAND |
| 9a. FACILITY NAME (If not in: | stitution, give str | set and number) | | | 9b. | CITY, TOW | N OR LOC | ATION OF D | | 17. | 9c. CO | UNTY OF E | DEATH |
| Greater I | | ore Medi | cal | Center | r | TOWSON BALTIMORE | | | | | | | MORE |
| 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR | | | | | | | CATION | | | | | | 10d, INSIDE CITY |
| MARYLAND | | | | | | | EUM | | | | | | 1 TES 2 NO |
| 104. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTY 24 Hathaway Rd. 21093 USA | | | | | | | | | WHAT COUNTRY? | | | | |
| 11. MARITAL STATUS | | | | N U.S. ARMEC | . 1 | 13 WAS I | ECENDEN: | T OF HISPA | NIC OBIGI | N? (Specify Y | a as Ma | | E — American Indian. |
| 1 Never Married 2 3 Widowed 4 Divor | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | WAR OR DA | ATES | | II yes, | specify,Cu | ban, Mexic O Speci | en, Puerto | Rican, etc.) | | Spec | ik, White, etc. offy: |
| 15, DECI | EDENT'S EDUCA | | WW I | | ENT'S USU/ | AL OCCUP | TION | | 1 401 | . KIND OF BU | IODIEGO III | | HITE |
| (Specify only Elementary/Secondary (0- | highest grade o | ompleted) | | (Give k | ind of work of NOT use retir | done during | most of wo | rking | 166 | KIND OF BU | Jamess/in | DUSTRY | |
| 12 | -12) | College (1-4 or 5 | ١) | Indus | stria | 1 Eng | ginee | r | | De | fense | 2 | |
| 17. FATHER'S NAME (First, Mi | | | | | | | 18. M | | | Middle, Meide | | | |
| | | nbrock | | | | | | Aı | nna C | . Jun | ker | | |
| 19a. INFORMANT'S NAME (7) Ann Leah | | | | | | | | | | ber, City or To | | | |
| 20g_METHOD OF DISPOSITION | ON | | 20h | PLACE AND | | | | • , | DAT | | OCATION - | | |
| 1 XBuriel 2 Cremation 4 Donation 5 Dother | n 3 Remov | val from State | cem | etery, cremato | ory or other pi | lace) | | | SEP | | | | |
| 21. SIGNATURE OF FUNERAL | | NESTE | 1.0 | ruid F | Kidge | | | RESS OF FA | | ттр | ikesy | rille | , MD |
| 1 | red M. | Lemmon | |) | | Lem | non F | unera | al Ho | me of | Du1a | ney | Valley, Inc. |
| p accus | 1961- | 1000 | h | / | | 10 T | T Do | dond | D.J | Train | an i | MD | 21093 |
| 23. PART (: Entar the diff shock, or he | art fallure. Li | implications that lst only one cau | t caused ise on ei | i the death. ach line. | . Do not e | nter the | node of | lying, suc | ch aa care | diac or reap | olratory a | rreat, | Approximate Interval Between |
| IMMEDIATE CAUSE (Findisesse or condition | al) | SPANT | ANO | FOVS | PN | EU | maT | -40 | RA | × | | | Onset and Death |
| resulting in death) | 8. | Spont CHR | (OR AS A | CONSEQUEN | NCE OF): | | | | 1770 | | | | C.117 |
| | | CHR | 5 W (| 1 | CUA | 16 | DIJ | ED | 5 | | | | İ |
| Sequentially list condition if any, leading to immed | ons, | | | CONSEQUEN | | | | | - | | | | |
| cause. Enter UNDERLY!! CAUSE (Disease or Injur | NG | | | | | | | | | | | | |
| that initiated eventa | | DUE TO | (OR AS A | CONSEQUEN | ICE OF): | | | | | | | | |
| resulting in death) LAST | d. | | | | | | | | | | | | + |
| PART II. Other algnificar | nt conditiona | contributing to | death b | ut not resu | iting in the | e underly | ing cause | given in | Part I. | 24a. WAS A | | 24b | . WERE AUTOPSY FINDINGS |
| Inche | 210 | HEB | RT | D17 | 183 | 6 | | | | PERFO | RMED? | - | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | _ | 1 123 | 2 (2410) | | OF DEATH? |
| DID TOBACCO US | | BUTE TO CA | USE O | F DEATH | YES-E | NO | □ UN | CERTAI | N 🗆 | | | | T TES 2 NO |
| 25. WAS CASE REFERRED TO EXAMINER? | | HOSPITAL: | | 26. PLACE OF | | neck only or | ne) | | | | | | |
| 1 TYES 2 -HO | | 1. Impatient 2 | ER/Outp | etlent 3 🗆 C | | | ome 5 🗆 | Rasidence | 6 🗆 Othe | r (Specify) | | | |
| 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | | |
| 1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | | | | | |
| | Could not be etermined | 28a. PLACE O building, | F INJURY etc. (Speci | — At home, i | larm, streat, | lactory, of | fice | | 261. LOC City | ATION (Street or Town, State | and Numbe | or Rural F | Route Number, |
| 29a. CERTIFIER | On CERTIFIER | | | | | | | | | | | | |
| (Check only | (Check only one) 14 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | |
| | | | | | mgmm/H, HI | у ориноп | | | | ena piece, e | nd que to t | ne cause(s | y and menner se stated. |
| 29b. SIGNATURE AND TITLE | / (| [A | | | | | 29c. Li | CENSE NUI | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| James H | - N & | アムー | - | | | | | 012 | 161 | | | \ 7 | 11/3/9/1/95 |

7401 Osler Drive, Balto., MD 21204



Reversed by Dr. V. Esch [Moderal Framus) BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

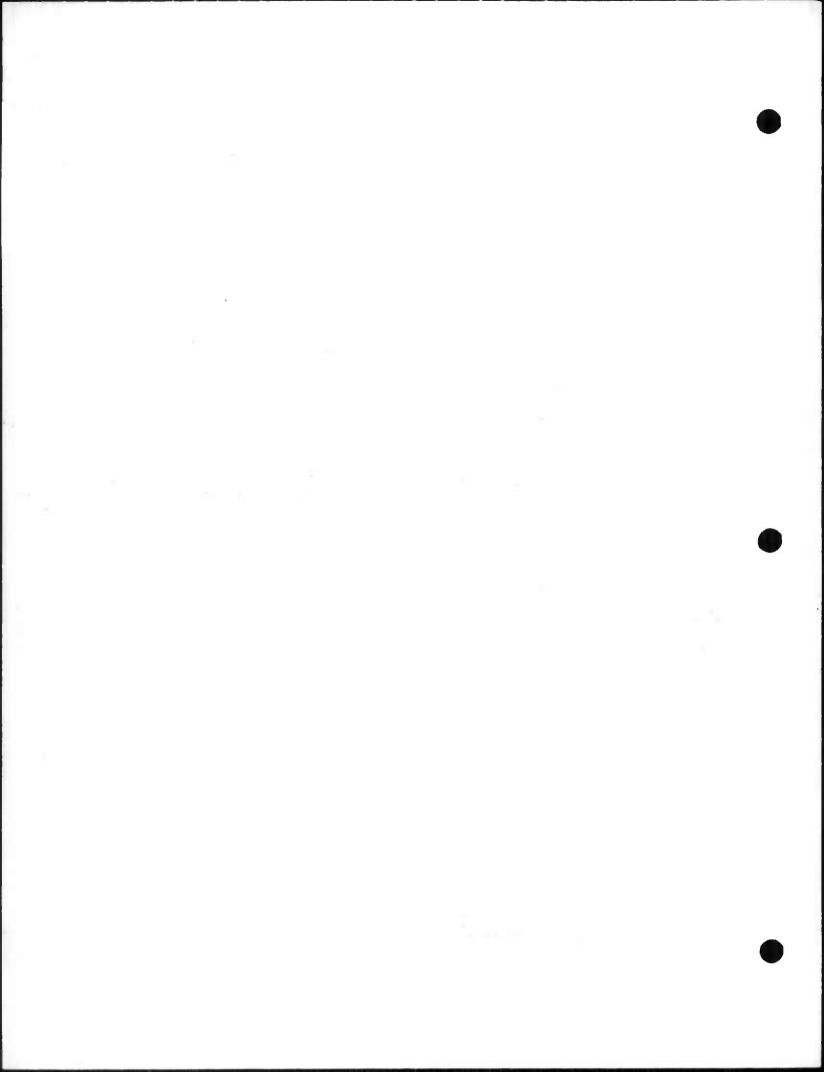
4

| O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| THE H | TO THE FL be filed w | IMPORT/ | |

| | FOR STATE REGISTRAR | STATE OF N | IARYLAND / CE | DEPAR | TMENT O | F HEALTH | AND | MENT | AL HYGIEN | | | |
|---------------|------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------|--------------------------------------|-----------------------------------------------------|---------------------------|------------|-------------|-------------------------------|--------------------------------------------|-------------------------|-------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Las | t) | | | | | | | E OF DEATH | | | 3. TIME OF DEATH |
| | Janice | Roths | schild | | | | | Aug | üst 31 | ,1995 | YEAR | 4:15pm w |
| | 4. SOCIAL SECURITY NUMBER 072 12 2573 | 5. SEX | 6. AGE (In yrs. lest 88 | | IF UNDER 1 YE | AR F UNDE | MIN. | | E OF BIRTH | 8. BIRTHPLACE (State or Foreig Country) | | |
| | | 1 M 2 1 F | | YRS. | | | | | UARY 9 | | | |
| œ | 9s. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF E | | | | | EATH | | |
| DIRECTOR | 6111 Montrose Ro | ad, #1002 | | | Rockville | | | | | Mon | tgom | ery |
| R | Maryland Mon | tgomery | | | CITY, TOWN OR LOCATION | | | | | | | 10d, INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | ROC | Rockville | | | | | , | | 1 - YES 2 NO | |
| FUNERAL | 6111 Montrose | Pood #100 | 12 | | | 20852 | E | | | USA | | /HAT COUNTRY? |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT | | IEO | 13. WAS | | OF HISPA | NIC ORIG | IN? (Specify Yes | | | American Indian, |
| BY FI | 1 Never Merried 2 Merried | FORCES? 1 | YES 2 NO | 0 | If ye | yes 2 NO | ın, Mexici | an, Puarto | | | Black Speci | , White, etc. |
| | 3 Widowed 4 Divorced | 1 | | | | Λ. | | | | | Whi | |
| TE | 15. DECEDENT'S Et (Specify only highest gra | de completed) | (GM | EDENT'S we kind of v Do NOT us | USUAL OCCU | PATION g most of worki | ng | | itle G | | | and |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+ | Secr | | | | | 1 - | ortgage | | | |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Last) | | | | | 16. MOT | HER'S NA | AME (First, | Middle, Malden | Sumame) | | |
| BE (| Adolf Wolfberg | | | | | | | Stra | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Arnold Weissha | - 20 | | | | | | | Maryla | | | |
| | 20a. METHOD OF DISPOSITION | ar | 20b. PLACE AF | | | | CLO | | | | | |
| ì | 1 🖾 Buriel 2 🗆 Cremation 3 🗆 Re 4 🗆 Donation 8 🗆 Other (Specify) | moval from Stata | cemetery, crem | natory or of | her place) | | 1 | | | CATION — | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Value | | | | | | | | | | | |
| | * Deme Ma | in their | 11 | | | | | | ral Ho 22046 | | | |
| | 23. PART I. Enter the diseases, o | r complications that | ceused the dee | th. Do n | ot enter the | mode of dy | ing, suc | th as car | ZZU40 | ratory an | reat, | Approximate |
| | shock, or heert fallum IMMEDIATE CAUSE (Finel | . List only one ceus | se on each line. | | | | | | | | 00.7 | Interval Between Onset and Death |
| | disease or condition Cerebral Vascular Accident | | | | | | | | | 1 hour | | |
| | h | DUE TO | OR AS A CONSECU | JENCE OF | 7): | | | | | | | |
| NO | Sequentially list conditions, Atherosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CAT | cause. Enter UNDERLYING | | | | | | | | | | | |
| Ë | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | |
| | PART ii. Other significent condition | ons contributing to | death but not re | sulting i | n the under | lying ceuse | given in | Part I. | 24s. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | | | | PERFOR | | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | 4 | 1 YES 2 NO |
| ä | DID TOBACCO USE CON | TRIBUTE TO CAL | | | | A | ERTAI | ИП | | | - | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 💢 YES 2 🗍 NO | HOSPITAL: | | | OTHER: | | | | | | | |
| HYS | 27. MANNER OF DEATH | 1 Inputient 2 I | | 28b. T/Mi | | Home 5 KR | sidence | | er (Specify) SCRIBE HOW II | N ILION OC | CHRED | |
| ВУ Р | 1 Netural 5 Pending | (Month, Da | y, Year) | INJ | URY | WORK? | NO | 200.00 | GOMBL HOW II | NOON! OC | DONED | |
| | 3 Suicide 8 Could not b | 28e. PLACE OF | INJURY — At hom ite. (Specify) | e, ferm, a | treet, factory, | office | | | CATION (Street a | ind Number | or Rural R | oute Number, |
| | 4 Homicide determined | | (Gpoory) | | | | | City | or Town, State) | | | |
| COMPLETED | | SICIAN: To the best of s | | | | | | | | | | |
| S I | 2 MEDICAL EXAMII | VER: On the basis of axi | amination end/or in | vestigation | n, in my opinio | rr, death occui | red at the | time, dat | e and place, an | d due to th | a cause(a) | and manner as stated. |
| BE (| 296. SIGNATURE VAID TITLE OF CENTUR | | | | 29c. LICI D35 | ENSE NUI | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) 1995 | |
| <u>P</u> | 30. NAME AND ADDRESS OF PERSON W | NO COMPLETED CANO | COE DESIGNATION | | | 10001 | | | | P 1 | ugus | 2 31, 1999 |
| | Stephen Vaccarezz | | | | | ville | . Ma: | ryla | nd 20 | 852 | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAF | I'S SIGNATURE | | | | | | | | | |
| | SEP 0 81995 | di dinde | 0 | | | | | | | | | |
| | 0 | | world | | | | | | | | | DHMH-16 Rev 1/89 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

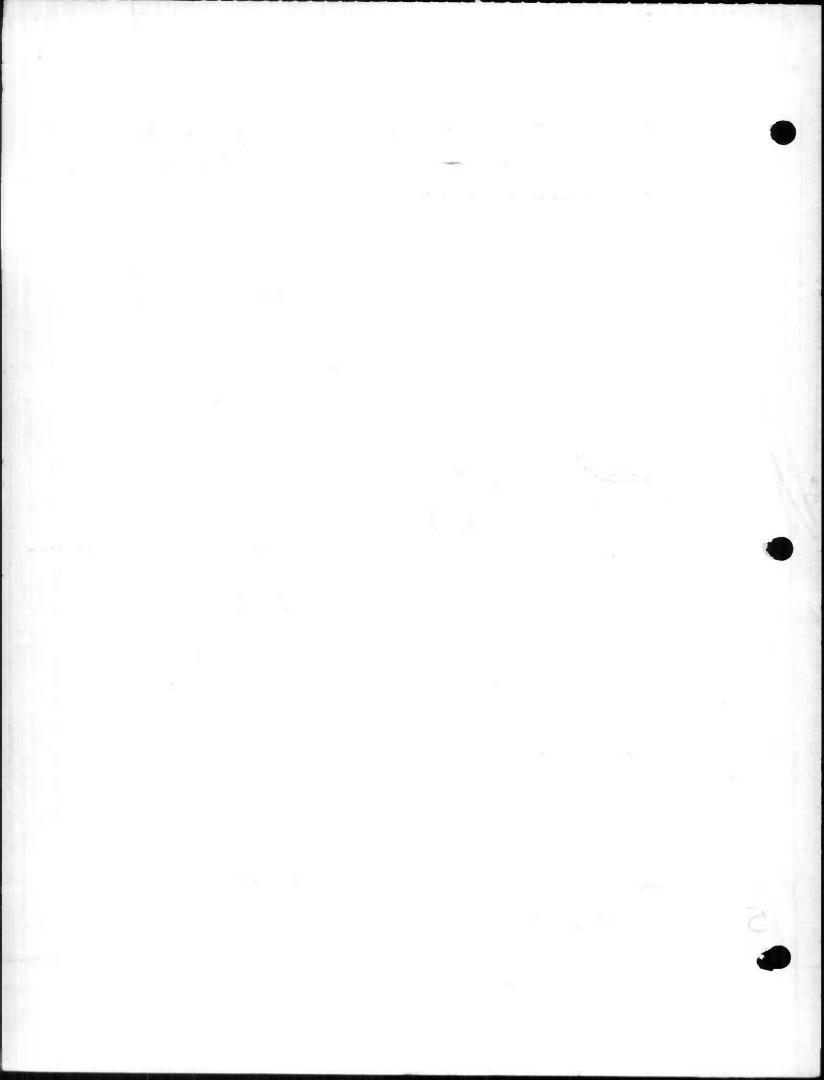
| | | REGISTRAR | | CERT | FICATE (| OF DEATH | REG. I | NO. | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------|--------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------|-------------------------|-------------------------------------------------------------------------|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | | Diane | | | OSIER | | September | | | | | |
| P | | 4. SOCIAL SECURITY NUMBER 216-38-3616 | 1 □ M 2 💢 F | (In yrs. lest birthde 54 YRS | MONTHS DA | | 7. DATE OF BIRTH (Month, Day, Year) February | ,5,1941 | 1 Virginia | | | |
| 3 should | e | 9a. FACILITY NAME (If not institution, give st | | | | WN OR LOCATION OF D | EATH | 9c. COUNT | TY OF DEATH | | | |
| 1, 2, | СТОВ | Franklin Square Ho | ospital . | | Ro | ssville | | Balt | imore | | | |
| Sages | | 10a. STATE 10b. COUNTY | | 10c. (| CITY, TOWN OR L | | | | 10d. INSIDE CITY | | | |
| permit. Pages | L D | Maryland Bal | ltimore | | Baltim | | | | 1 TES 2 NO | | | |
| 150 | FUNERAL | 5761 Utrecht Road | | | | 101. ZIP CODE 21206 | | | U.S.A. | | | |
| 2 2 2 | BY | 1 Never Merried 2 Married 3 Widowed 4 X Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | It yes | DECENDENT OF HISPA I, specify Cuban, Mexico YES 2 X NO Speci | en, Puerto Rican, etc.) | Yea or No.— 1 | 4. RACE — American Indian, Black, White, etc. Specify: - White | | | |
| r attend | 9 | 15. DECEDENT'S EDUC (Specify only highest grade | 16b. KIND OF | BUSINESS/INDU | | | | | | | | |
| spital or ned for t | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | 1 | of work done during use retired.) Strative | e Assistan | t Apt. | Comple | ex | | | |
| the hospin detached detached | NO. | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, Maid | | | | | |
| व द द | BE | Charles Sanyour | | | | | ell Tuoh | | | | | |
| fretained by the should be at notified at | 5 | 19a. INFORMANT'S NAME (Type/Print) | | | | eet and Number or Rural | | | lode) | | | |
| | | Mr. William D. Wa | | | 3 Cheste | erfield Av | | | ty or Town, Stats | | | |
| rector, y | | 1 Burial 2 Cremation 3 Remo | oval from State can | netery crematory of | Service | Corp. 9/9 | /95 Tow | | Maryland | | | |
| DALLIMORE, after death. Page 6 may by the funeral director, page moval. ical examiner must be | | 21. SIGNATURE OF FUNERAL SERVICE LICI | ENSEE On . | | 22. NAM | e and address of Fa | CILITY | | | | | |
| DAL ter deat the fun wal. | 2. 1 | John & | · Jan | | | | | | Maryland 212 | | | |
| Si ii | | 23. PART I. Enter the displaces, or contained the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o | omplications that ceuse list only one cause on a | d the deeth. De | not enter the | mode of dying, aud | h as cardiac or re- | piratory arres | st, Approximate | | | |
| F 9 = 7 | | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | |
| E 5 8 | | Pancreatic cancer a. Pancreatic cancer Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 9 5 3 6 | z | | 202 70 (011 22 2 | CONSCOUENCE | or). | | | | | | | |
| be executed in the property of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c | CATION | Sequentisity list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ficate be physician ne prior h | ICA | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| ding the second | RTIF | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| death demtal | 뮝 | PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUT | | | | | | | | | | |
| # 55 - | EDICAL | PART II. Other aignificent conditions | contributing to deeth b | out not resultin | g in the under | ying cause given in | | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| | | | | | | | 1 D YES | 2 NO | OF DEATH? | | | |
| w requirements been so the of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statem | Σ ÿ | DID TOBACCO USE CONTR | IBUTE TO CAUSE O | F DEATH | YES NO | INCERTAIL | N I | | 1 TYES 2 NO | | | |
| : The law cate has be State Dept. | CIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | EATH (Check only | | | | | | | |
| SICIAN: The certificate the State | YSICI | 1 TYES 2 NO | HOSPITAL: 1 ⊠ Inpetient 2 □ ER/Outp | patient 3 🗆 DOA | OTHER: | iome 5 🗆 Residence | 8 Other (Specify) | | | | | |
| NG PHYSIC tter this ce eath with t | ву рну | 27. MANNER OF DEATH 1 🔀 Naturel 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | | NJURY | INJURY AT WORK? YES 2 NO | 28d. DESCRIBE HON | V INJURY OCCU | RED | | | |
| TTENDI TTOR: A after de | | 3 Suicide 8 Could not be determined | 25e. PLACE OF INJURY building, etc. (Spec | — At home, larm | n, atreet, lactory, o | office | 281. LOCATION (Stree City or Town, Sta | et and Number or te) | Rural Route Number, | | | |
| DIR DIR | PLET | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC | IAN: To the beat of my know | ledge, death occu | irred at the time | tate and place, and due | to the reveels) and a | anner se stated | | | | |
| HOSPITAL FUNERAL within 72 h | COMPL | | | | | | | | cause(a) and manner as stated. | | | |
| THE HOSPI THE FUNE filed within | | 296. SIGNATURE AND TITLE OF CERTIFIER | V . | | | 29c. LICENSE NUI | | | BIONED (Month, Day, Year) | | | |
| 5 5 3 M | O BE | 11/- | - Ms | 0 | | D301 | 53 | Þ 9 | -7-95 | | | |
| y! | - | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | |
| 0 | | Maria Diaz, M.I | | | Baltimo | re, MD 21 | 220 | | | | | |
| | | SEP 0 8 1995 | 32 REGISTRAR'S CON | Kell | | | | | | | | |



| BALTIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should https: Strould be detached for use as the burial-transit permit. Pages 1, 2, 3 should https: Strould be Strould by the State Dept. of Health and Mernal Hygiene prior to burial, cremation, or removal. | ne medical examiner must be notified at once. |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| FOR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYCIENE |
|-----------|-----------------------------------------------------|---------|
| STATE | OTALE OF MANITEMENT OF MEALITY AND MENTAL | HIGHERY |
| REGISTRAR | CERTIFICATE OF DEATH | REG NO. |

| | REGISTRAR | CERTIF | CATE OF | DEATH | REG. | NO. | | | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------|---------------------------|--------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 2 | | | 2. DATE OF DEAT | H DAY | VEAR 3. T | IME OF DEATN | | | |
| 1 | Louise A. Str. | FIFER | | | 9 | 6 9 | f | 10:31 A M | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPLAC Country) | CE (State or Foreign | | | |
| | 212-48-4632 1 M 2 DA | 9 4 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) Country) MARYLAND | | | | | | |
| | Se. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN C | | | TY OF DEATH | | | | | |
| Œ | Bon Lecours Hos | en Fro | RA. | LTIMORE | | DATT | IMORE | CTTV | | | |
| 2 | RESIDENCE OF DECEDENT | | DA | LITTORE | | DALI | INOKE | CITI | | | |
| DIRECTOR | ton. STATE 16b. COUNTY | 10c. CITY | , TOWN OR LOCAT | ION | | | 10d | INSIDE CITY | | | |
| <u>E</u> | MARYLAND BALTIMORE CITY | RA. | LTIMORE | | | | 1.15 | LIMITS? YES 2 NO | | | |
| | too. STREET AND NUMBER | Di | | ZIR CODE | | I son CITIZI | EN OF WHAT | | | | |
| A I | 3656 GREENVALE ROAD | | 10f. ZIP CODE | | | | | | | | |
| FUNERAL | | | | 21229 | | | U.S.A. | | | | |
| 2 | tt. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? t YES | | | ENDENT OF HISPAN | | | 14. RACE — A Black, Wh | American Indian, ilta, atc. | | | |
| BY | 1 Never Married 2 Married IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR DATE IF YES, GIVE WAR OR | | | 2X NO Specify | | 2 | Specify: | WHITE | | | |
| | | | | | | | | | | | |
| E | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a, DECEDENT'S (Give kind of w | vork done durina mo | ON st of working | 16b. KIND O | 9USINESS/INDU | ISTRY | | | | |
| Ш | Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT us | | | | | | | | | |
| P | 6TH GRADE | HOMEMA | KER | | | HOMEMAK | ING | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | ME (First Middle, M. | siden Surname) | | | | | |
| | HARRY E. CROMWELL | | | JULIA I | RANDALL | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING | ADDRESS (Street a | nd Number of Rural F | Route Number, City of | r Town, State, Zip (| Gode) | | | | |
| 2 | ELAINE SHAFFER | 3656 | REENVAL | E ROAD - | BALTIMO | RE. MD | 21229 | | | | |
| | 2Q4 METNOD OF DISPOSITION 20b. | PLACE AND DATE O | | | | c. LOCATION — C | | Rtata | | | |
| | | | | | | | | | | | |
| | t O Buriel 2 Cremation 3 Removel from State Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete C | | | | | | | | | | |
| | 221 - 111 | 01 | | RD FUNERA | | INC. | | | | | |
| | > Jusa Kly | X | | WILKENS A | | | F MD | 21229 | | | |
| | 23. PART I. Enter the diseases, or complications that capital | the death. Do n | | | | | | Approximate | | | |
| | shock, or heart fallure. List only one ceuse in each lide. | | | | | | | | | | |
| - 1 | | | | | | | | | | | |
| - 1 | IMMEDIATE CAUSE (Final disease or condition reaulting in death) A consequence of: Due to (or as a consequence of): Crayesta Heart Frilam b. | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): Heart Frileen | | | | | | | | | | |
| N | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Obstructe In (brown Della) | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | CONSEQUENCE OF | Obstr | mes | Par 160 | non 15 | | | | | |
| 3 | CAUSE (Disease or Injury | | | | | 7 | CEA | | | | |
| E | DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| E | d. | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but | ut not resulting | in the underlyin | a ceuse alven in | Part I. 24s. W | S AN AUTOPSY | 24b. WE | RE AUTOPSY FINDINGS | | | |
| EDICAL | Enstern Gears | | | | PE | RFORMED? | AVA | ILABLE PRIOR TO WPLETION OF CAUSE | | | |
| ă | | | | | 1 🗆 Y | ES 2 MO | | DEATH? | | | |
| ME | | | | | | | 1 (| YES 2 NO | | | |
| ż | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | F DEATH YE | S NO C | UNCERTAIL | N 🗆 | | | | | | |
| ¥ | | 26. PLACE OF DEAT | - | | | | | | | | |
| Sic | t YES 2 NO HOSPITAL: | atlant 3 🗆 DOA | OTHER: 4 Nursing Hon | ne 5 - Realdence | 6 Other (Specify |) | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 28e. OATE OF INJURY | 28b. TIM | | JURY AT | 28d. OESCRIBE | IOW INJURY OCC | UREO | | | | |
| | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation | 114. | | YES 2 NO | | | | | | | |
| BY | 3 Suicide 28e, PLACE OF INJURY | | street, fectory, offic | | | treet and Number | or Rural Route | Number, | | | |
| ED | 4 Homicide determined building, etc. (Special Special | | City or Town, State) | | | | | | | | |
| <u>u</u> | 29a. CERTIFIER | | | Company of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the las | | . Valley | _ | | | | |
| COMPLET | (Check only | | | | | | | | | | |
| 0 | 2 MEDICAL EXAMINER: On the besis of axamination | and/or investigation | on, in my opinion, o | feath occured at the | time, data and pla | ce, and due to the | cause(s) an | d manner as stated. | | | |
| Ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUI | | 29d. DATE | SIGNED (Ma | nth, Day, Year) | | | |
| 00 | Holens hhh renty. | an. | | 004 | 1872 | • | 9/4/ | 81 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA | ATN (ITEM 27) (Type | , Print) | | | | | | | | |
| | RoLeab. a Sooun on | 4 4. | | | | | | | | | |
| | 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGN/ | | | | | | | | | | |
| | SEP 0 8 1995 July Staveler Ray | 1_11 | | | | | | | | | |
| | All the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | A21,443 | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be need to be a state death with the State Cept. of Health and Mental Hygiene prior to burial, cremation, or removal.

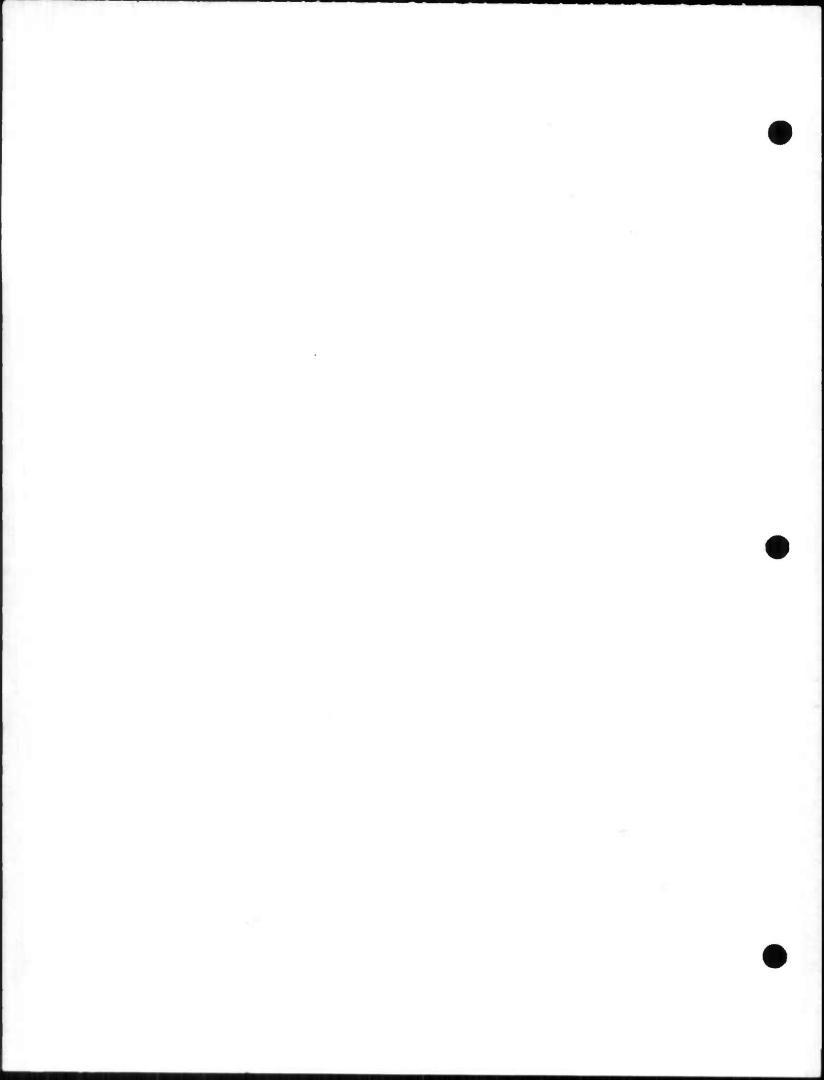
IMPORTANT If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitlified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

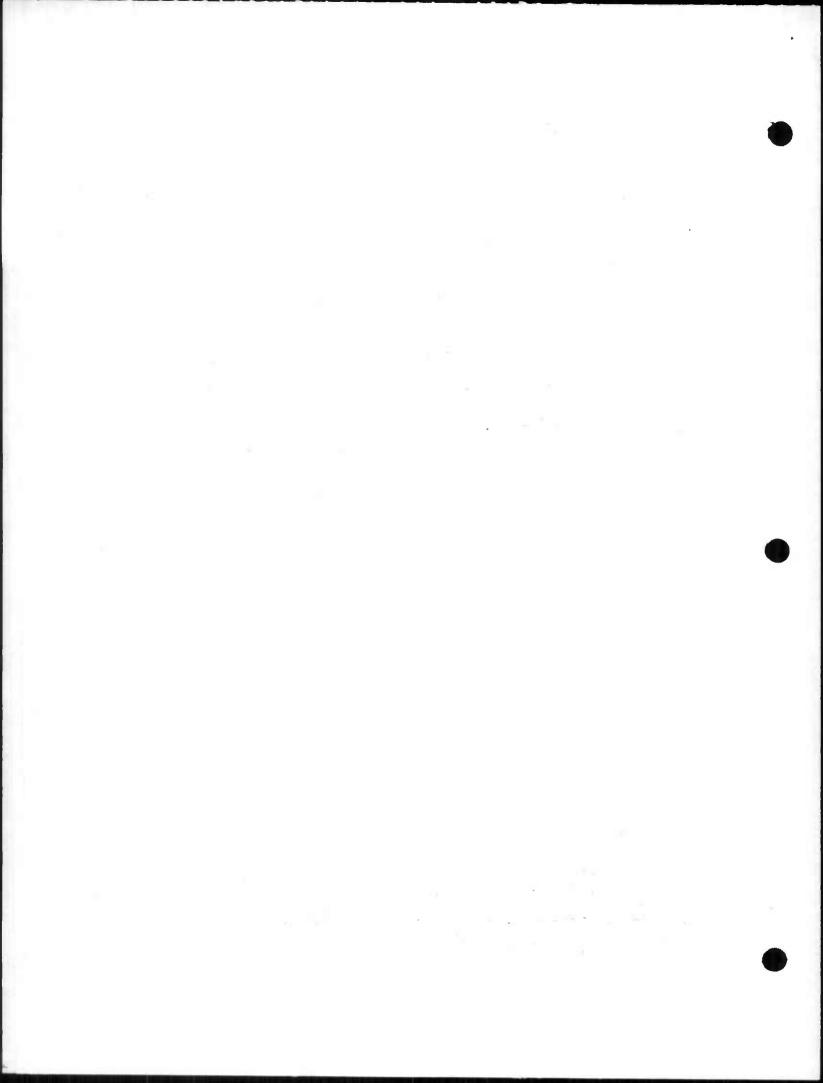
| | 1. DECEDENT'S NAME (First, Frank E. | | vers | | | | | | | 2. DATE OF I | DA | 199 | YEAR | 3. TIME OF DEATH 8:30 CM |
|--------------|------------------------------------------------------------------------|-------------------------------|---------------------------------------|------------------|-----------------------------------------------------|----------------------------------|---------------------------------------------------------|-------------------------|-----------|-----------------------|---------------------|---------------------------------------------|------------|----------------------------------------------|
| | 4. SOCIAL SECURITY NUMBI | ER | 5. SEX | 6. AGE (In yr: | s. lest birthday) | IF UNDER | 1 YEAR | IF UNDER | | 7. DATE OF E | BIRTH | 8. BIRTHPLACE (State or Foreign Country) | | |
| | 216-20-5 | 618 | 1 0 M 2 - F | 68 | YRS. | MONTHS | DAYS | HOURS | MIN. | March March | | .19 | | Maryland |
| | 9s. FACILITY NAME (If not institution, give street and number) | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | |
| 5 | 802 Melville Ave. | | | | | | Baltimore N/A | | | | | | | |
| 5 | RESIDENCE OF DEC | 10b. COUNTY | , | | 100 00 | TY, TOWN OR LOCATION 10d. INSIDE | | | | | 10d. INSIDE CITY | | | |
| | Maryland | N/Z | | | Baltimore | | | | | | | | | LIMITS? |
| ן נ | 10e, STREET AND NUMBER | | | | Da | TCIII | | f. ZIP COD | F | tog. CITIZEN OF WHA | | | | |
| | 802 Melvil | le | | | | 21218 | | | | | | US | | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDER | | | | WAS DE | CENDENT (| OF HISPAN | IIC ORIGIN? (S | | or No- | 14. RACE | - American Indian, |
| | 1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | | | | pecify Cube 3 2 M NO | | n, Puerto Rica: /: | n, etc.) | | Speci | k, White, etc. |
| 0 | 3 Widowed 4 Divor | | <u> </u> | | | | | | | | | | | Black |
| | t5. DECt (Specify only | EDENT'S EDU- highest grade | CATION completed) | 164 | (Give kind of life, Do NOT u | work done | during m | | ng | 16b. KIN | D OF BUS | SINESS/IND | DUSTRY | |
| L' | Elementary/Secondary (0- | l-12) | College (1-4 or 5 | | | or Operator | | | | 7 | | | | |
| N. | 17. FATHER'S NAME (First, Mi | iririin (net) | _1 | | ILact | 01 (| pher | | | ME (First, Midd | Ste | | | |
| 5 | Frank Stan | | Seivers | | | | | | | Harri | | Jamemey | | |
| ממ | 19s. INFORMANT'S NAME (7) | | | | 19b. MAILING | 3 ADDRES | \$ (Street | | | Route Number, (| | n, State, Zip | Code) | |
| 2 | Marlene Se | ivers | 3 | | 802 | Melv | rill | e A | ve. | Balto | . M | d. 2 | 2121 | 8 |
| | 20s. METHOD OF DISPOSITI | ION 2 Page | and from State | | | | | | | | CATION - | ON — City or Town, State | | |
| | 4 Donation 5 Other | | Oval Holli State | | y, crematory or other place) Outus Mem. Park Balto. | | | | | | lto. | o. Md. | | |
| | 21. SIGNATURE OF FUNERAL | L SERVICE LI | CENSEE |) | 0 | | | ND ADDRE | | | 0 | | | |
| | (andt | lan | C. h | long | Jans | / | - | | | neral | | LATC | e | |
| | | eart fallure. | complications the List only one ca | | | | | | | | | ratory ar | rest, | Approximate interval Between Onset and Death |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | 1 ments | | |
| 2 | Sequentially list conditions, DUE TO ION AS A CONSEQUENCE OF: | | | | | | | | | | | | | |
| 2 | If any, results to manetale | | | | | | | | | | | | | |
| 3 | Cause. Enter UNDERLYI CAUSE (Disease or Inju | | - /// | erT41 | MICA | | | | | | | | 20 yrs | |
| CEMILIFI | thet initiated eventa reaulting in death) LAS | т | 1 | 6 CR | | | | | | | | 5100 | | |
| 3 | | | | 1 | | | | | | | | | | + // ' |
| AL | PART II. Other algnifice | ent condition | ns contributing to | death but | not reaulting | In the u | nderlyli | ng cause | given in | Part I. 24 | a. WAS AN PERFOR | | 24b | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 2 | | | | | | | | | | 1 | YES 2 | KNO | | OF DEATH? |
| Ā | | | | | | | | - | | | | | | 1 TYES 2 NO |
| PHYSICIAN: N | DID TOBACCO U | | RIBUTE TO CA | | PLACE OF OE | | | | ERTAI | иЦ | | | | |
| 3 | 25. WAS CASE REFERRED TO EXAMINER? | U MEDICAL | HOSPITAL: | | 311 | OTHE | R: | | 3-4-77 | | | | | |
| 2 | 1 TYES 2 NO | | 1 Inpetient 2 | | 28b. TI | | | me 5 PS-R | esidence | 6 Other (S | | N.IURY OC | CUBED | |
| | 1 Natural 5 | Pending | (Month, | Day, Year) | 18 | JURY | W | YES 2 | □ NO | 200. 023011 | IDE TION | | CONED | |
| 19 | a Catalda | Investigation | 28s. PLACE | OF INJURY - | At home, farm, | street, fac | | | | 281, LOCATIO | ON (Street: | and Numbe | r or Rural | Route Number, |
| COMPLETED | | Could not be determined | building | , etc. (Specify) | | | | | | City or 1 | own, State) | | | |
| 4 | 29s. CERTIFIER 1 CERT | TIFYING PHYS | ICIAN: To the best of | of my knowledg | e, death occur | red at the | time, dat | ts and place | s, and du | to the cause(| a) and ma | nner ss sta | rted. | |
| 1 | CONDON ONLY | | | | | | | | | | | | | s) and manner as stated. |
| | 286. SCHATURE AND TITLE | OF CERTIFIE | 4 | | | | | 29c. LIC | ENSE NU | MBER | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| BE | | 11 | V HO | | | | | 0. | 3333 | 0 | | 15 | ENT. | 7 1195 |
| 5 | 30. NAME AND ADDRESS OF | | O COMPLETEO CA | JSE OF DEATH | (ITEM 27) (Typ | e, Print) | | | | . / | _ | 0 | 1 | 1. 21218 |
| 1 | JOhn For | Stoke | 1 /V MA | 33) | 3 N. | Colu | er7 | M | Su | itch | 50 | 1341 | BN | 1.21218 |
| | SEP 0 819 | 95 | al died | AR'S SIGNATI | 14_ | | | | | | | | | |



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages is filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| THE HOSPITAL OR ATTENDING PH THE FUNERAL DIRECTOR: After this filed within 72 hours after death wif PORTANT: If Item 28 is marke | |

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | C | ERIIF | ICATE | F DEATH | REG. NO | | | | | |
|---------------|----------------------------------------------------------------------------------------------|-----------------------------------------|--------------------|-------------------------------------------|------------------|---------------------------------------------------|---------------------------------------------|----------------|------------|-------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | _ | 14 | | | 2. DATE OF DEATH MONTH D | AY | YEAR | 3. TIME OF DEATH | | |
| | WILLIAM I | HOMAS | | HAF | 395 | | SSPT. 2 | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la | | IF UNDER 1 YEA | | 7. DATE OF BIRTH (Month, Day, Year) | | B. BIRTH | PLACE (State or Foreign y) | | |
| | POER COPIE | 107 2309 1XM2 0 F 75 YR | | | | | Nov-3 19 | 119 | MAI | RYLAND | | |
| | 90. FACILITY NAME (If not institution, give street end number) 2703 JOPPA ISRRACS | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | EATH | | |
| 6 | 2703 JOPPA | | LAR | | BA. | 7110 | nore | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | , | | 10c. CIT | Y, TOWN OR LO | CATION | | | | 10d. INSIDE CITY | | |
| E | Marylan Bai | T:mnes | | | CARN | sy | | 1 WES 254 NO | | | | |
| | 10e. STREET AND NUMBER | | <u></u> | 101. ZIP CODE | | 10g. CITI | ZEN OF V | VHAT COUNTRY? | | | | |
| FUNERAL | 2703 JOPPE | ITRR | 77A | | | 4 | | ULS | A. | | | |
| S | 11. MARITAL STATUS | 12. WAS DECEDEN | | | | | NIC ORIGIN? (Specify Ye | s or No- | 14. RACE | — American Indian, c, White, etc. | | |
| | 1 Never Merried 2 Married | FORCES? 1 tF YES, GIVE W | YES 2 | ÎΝΟ | | epecify Cuben, Mexica ES 2 NO Specifi | | | Spec | | | |
| BY | 3 Widowed 4 Divorced | l | | | 1 | | | 1 | U | 311/2 | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | (| ECEDENT'S Give kind of le. Do NOT u | WORK done during | NTION most of working | 16b. KIND OF BU | SINESS/IND | USTRY | | | |
| Ľ | Elementery/Secondery (0-12) | College (1-4 or 5+ |) = 0 | ~ : 1 : ~ | | S. C. L | 000 | m | 00. | 9902 ATTE | | |
| ME | 17. FATHER'S NAME (First, Middle, Lest) | 3/1/2. | | | 11200 | 18. MOTHER'S NAME (First, Middle, Melden Surneme) | | | | | | |
| | 1.7:11:000 - | 20 mal | SCH | 000 | | Helen | VERO | 100 | Ra | 20 | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | HOLIES | - | | | et end Number or Rural | Route Number, City or Toy | vn. State. Zip | - | : A12314 | | |
| 2 | CHEDISO A SE | HARPS | | 3703 | JAPE | O TERR | Ars CAG | 420 | MA | RYLADO | | |
| | 20e, METHOD OF DISPOSITION Suriel 2 Cremation 3 Rem | | | AND DATE | OF DISPOSITION | (Name of | DATE 20c. LC | CATION - | City or To | own, State | | |
| | PS Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | ovel from State | Cemetery, co | remetory or o | ther place | Isma RiAL | 8.5 | noi | inm | MARYLAGO | | |
| | 21. SIGNATURE OF PUHERAL SERVICE LIE | CENSUS | 1000 | | | AND ADDRESS OF FA | CILITY F MEC | roRi | 22 | 1 | | |
| | 1201 | 5_ / | | | SVA | UZ CHAP | TOLI SI | Par | TI : | 110 | | |
| _ | 23. PART i. Enter the disesses, or | complications the | Caused the d | leath. Do | 758 | MAKEO | th as cardiac or read | tratory an | | Approximate | | |
| | shock, or heart fallure. | List only one cel | se on each lin | ie. | | | | | , | Interval Between Onset and Death | | |
| | disease or condition Dissem in fed diffuse histographic lumphone | | | | | | | | | | | |
| | resulting In death) DUE TO (OR AS A CONSEDUENCE OF): | | | | | | | | | | | |
| z | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CA | CAUSE (Disease or Injury | | | | | | | | | | | |
| TE | that initiated events DUE TO (OR AS A CONSEDUENCE OF): | | | | | | | | | | | |
| ER | resulting in death) LAST | | | | | | | | | | | |
| | PART ii. Other significant condition | ns contributing to | death but not | reauiting | in the underl | ying cause given in | Part i. 24s. WAS A | | 248 | . WERE AUTOPSY FINDINGS | | |
| EDICAL | | | | | | | PERFO | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | | | | | | | | Tag ino | 1 | OF DEATH? | | |
| . X | DID TOBACCO USE CONT | RIBUTE TO CA | USE OF DE | ATH Y | ES NO | M UNCERTAL | N 🗆 | | | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | TH (Check only o | ne) | | | | | | |
| PHYSICIAN: | EXAMINER? 1 TYES NO | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | tome 50 Residence | 6 Other (Specify) | | | | | |
| Ήλ | 27. MANNER OF DEATH | 28e. DATE OF (Month, D | | 28b. Til | AE OF 28c. | INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OC | CURED | | | |
| BY F | Natural 5 Pending 2 Accident Investigation | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ,,, | | | YES 2 NO | | | | | | |
| ED E | 3 Suicide 8 Could not be | 28e. PLACE C building, | F INJURY — At I | home, term, | street, tectory, | office | 26t. LOCATION (Street City or Town, Steh | end Number | r or Rural | Floute Number, | | |
| E | 4 Homicide determined | | | | | | | | | | | |
| P | 29e. CERTIFIER (Check only | SICIAN: To the beat of | my knowledge, | death occur | red at the time, | date end place, and du | e to the ceuse(a) end m | enner ee sta | ted. | | | |
| COMPL | one) 2 MEDICAL EXAMIN | ER: On the besie of e | xemination end/o | r Investigati | on, in my opinio | n, death occured at the | e time, date end place, e | end due to ti | he ceuse(| a) end manner as stated. | | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIE | 9// | | | | 29c. LICENSE NU | MBER | 29d. DAT | E SIDNE | O (Month, Day, Year) | | |
| m | Haw! | | | 0165 | 87 | 21 | 792 | 5 1995 | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAU | SE OF DEATH (IT | EM 27) (Typ | | | | ~ | 1 | | | |
| | DR TAUL CHAN | 6 5 b | 10 To | · Hi | AVIO | BLVO. | BALTO. | PAR | Ads | 00 | | |
| | SEP 0 8 1995 | 32. DEGISTR | R'S SIGNATURE | H | | | | | | | | |
| | I CED A QUUL | \Jb / L | | | | | | | | | | |



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| 124 | ly fille | ation |
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| paecuted | and cor | bunial o |
| e pe | sician | whor h |
| TTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 hours after death, Page 6 may be retained to | TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should by | Auniana n |
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| that | D D | 4 20 |
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| E I | cate | Compa |
| SICIA | certifi | - Spin |
| PHY. | this | dans |
| DING | After | dansh |
| LEN | 30R | - family |

y the hospital or attending physician. be detached for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bost TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buital, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF | MARYLAND / | DEPARTMENT | OF I | HEALTH | AND | MENTAL | HYGIENE |
|----------|------------|------------|------|--------|-----|--------|----------|
| | CE | ERTIFICATE | OF | DEAT | Ή | | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYLAND / DE | EPARTMENT OF H | | MENTAL HYGIENI REG. NO. | E | | | | | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------|-----------------------|-----------------------------------------|----------------------|-------------------------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | onse Liwi | c CHIFFLST | T. SR. | | MONTH DA | 1995 YEAR | 9 15 814 | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. | SEX 6. AGE (In yrs. lest bin | thday) IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | a. BIRT | HPLACE (State or Foreign | | | | |
| | 96. FACILITY NAME (If not institution, give street | | YRS. MONTHS DAYS | HOURS MIN. | 7751-11 | IN LIE | REINIA | | | | |
| TOR | ST. JOSEPH HOSEOL IZ | LATIAZ | Tows | | BATTIMORE | | | | | | |
| E . | RESIDENCE OF DECEDENT 10s. STATE 10b. CDUNTY | 10 | | 10d. INSIDE CITY | | | | | | | |
| DIRECTOR | MARYLAND BALT | imore | LUTHE | RVIUS | | LIMITS? 1 ☐ YES 2 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER | Rann | 101 | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | |
| W | 1409 CHAROUT | . WAS DECEDENT EVER IN U.S. ARMED | D 13 WAS DEC | 2 | IIC ORIGIN? (Specify Yes | or No 14. RA | 14. RACE — American Indian, | | | | |
| 3 | 1 Never Merried 2 Merried | FORCES? YES 2 NO | If yes, sp | | n, Puerto Rican, etc.) | Bie | ok, White, etc. | | | | |
| 8 | 3 Widowed 4 Divorced | W.W.JI | , | a page 110 opening | | l G | 377/60 | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATH (Specify only highest grade com | ioleted) (Give I | DENT'S USUAL OCCUPATION | ON st of working | 16b. KIND OF BUS | INESS/INDUSTRY | | | | | |
| 9 | Elementary/Secondary (0-12) C | ollege (1-4 or 5+) | NOT use retired.) | 1 110 | 0 | - | 0 - 0 | | | | |
| MP | 8 1/0. | 11605 | 1057-11 | CHADIC | Unun | LAINS | LAN LO. | | | | |
| | 17, FATHER'S NAME (First, Middle, Last) | Wireland | | IE. MOTHER'S NA | ME (First, Middle, Melden | | _ | | | | |
| 8 | 19a, INFORMANT'S NAME (Type/Print) | 20(1FF) | IAILING ADDRESS (Street a | and Number or Rurel I | | A WSOY | \$1093 | | | | |
| 5 | MYRTT & MOR CH | icel (77 145) | DACHORO | HTIL | ROAD LU | THERV | Us Parlon | | | | |
| | 20a, METHOD OF DISPOSITION | 20b. PLACE AND | DATE OF DISPOSITION (Ne | me of | DATE 20c. LO | CATION — City or | Town, State | | | | |
| | Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify) | from State DULAC | tory or other place) | BrokiA | 95 110 | nonium | 2. MARYLAND | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENSE | #E | 22. NAME AI | D ADDRESS OF FA | SET OF CH | ious | | | | | |
| | I Wash die | Donor | 232 | YERK | Roso - | -Tima | nium | | | | |
| | 23. PART i. Enter the diseases, or com | | n. Do not enter the mo | de of dying, suc | h as cardiac or respi | | Approximate | | | | |
| | ahock, or haart fallure. List IMMEDIATE CAUSE (Final | only one cause on each line. | | | | 1 | Interval Between Onset and Death | | | | |
| | MMEDIATE CAUSE (Final disease or condition) Cardiac arrest (myocardeal inforct | | | | | | | | | | |
| | DUE TO (DR AS A CONSEDUENCE DF): | | | | | | | | | | |
| z | Sequentielly list conditions, | | | | | | | | | | |
| CERTIFICATION | Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING Cause. Enter UNDERLYING Cause. Enter UNDERLYING | | | | | | | | | | |
| 2 | CAUSE (Disease or injury C | DUE TO (OR AS A CONSEQUE | ENCE DEL | allon | | | | | | | |
| E | that initiated events resulting in death) LAST | 000000000000000000000000000000000000000 | | | | | | | | | |
| CE | d | | | | | | | | | | |
| AL | PART ii. Other algnificent conditions conditions | ontributing to death but not read | uiting in the underlyin | g causa givan in | Part i. 24a. WAS AN PERFOR | | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | |
| DIC | | | | | 1 _ YES 2 | NO NO | OF DEATH? | | | | |
| M | | | | | | | 1 TYES 2 NO | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIB | | F DEATH (Check only one) | UNCERTAI | N L J | | | | | | |
| ICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | OTHER: | | | | | | | | |
| HYS | 1 VES 2 NO 1 | ☐ Inpetient 2 | | te 5 ∐ Rasidence | 6 Other (Specify) 28d, DESCRIBE HOW I | NJURY OCCURED | | | | | |
| | Netural 5 Pending | (Month, Day, Year) | INJURY WO | YES 2 NO | 000 01000000000000000000000000000000000 | | | | | | |
| 84 | 2 Accident Investigation 3 Suicide 6 Could not be | 26e. PLACE DF INJURY — At home | , farm, street, factory, offic | :8 | 28f. LOCATION (Street | | al Route Number, | | | | |
| TED | 4 Homicide determined | building, etc. (Specify) | | | City or Town, State) | | | | | | |
| J. | 290. CERTIFIER 1 CERTIFYING PHYSICIAL | N: To the best of my knowledge, death | occurred at the time, date | and place, and due | to the cause(a) and me | nner as stated. | | | | | |
| COMPLET | (Olleck Olly | On the basis of axaminstion and/or inve | | | | | e(s) and manner as stated. | | | | |
| EC | 29b. FIGNATURE AND THE DE CERTIFIER | 1 | ^ | 29c. LICENSE NU | MBER | 29d. DATE SIGN | ED (Month, Day, Year) | | | | |
| 00 | 10 la Mana | tell m! | D221 | 233 | 1250 | 1.5.1995 | | | | | |
| 70 | 30. NAME AND ADDRESS OF PERSON WHO C | DMPLETED CAUSE OF DEATH (ITEM 2 | 27) (Type, Print) | | ^ | , and | | | | | |
| | UR IRA 11. | LEGORAL | 1818 101 | - SPR: | No KOA | 2-407 | HERVILLE | | | | |
| | SEP 0 8 1995 | 32. REGISTRAR'S SIGNATURE | | | 34 | 127 | | | | | |
| | JEL 0 9 1333 July | Develor Rock | | | | | DHMH-16 Rev 1/89 | | | | |
| | | | | | | | THIMPL 15 Rev 1/9 | | | | |

| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | The function of the attending physician and completely filled in by the functal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should he detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL DR ATTENDING PHYSICIAL | TO THE FUNERAL DIRECTOR: After this certif | IMPORTANT: If item 28 is marked, or | |

| | | | | | | | | 2 | 1 | 1000 |
|--------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------|-------------------------|--------------------|---------------|-----------------------|-----------------------------|--------------------------|-------------------------------------|
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | | RTMENT OF H | | MENTA | L HYGIENI REG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | MONT | OF DEATH | Y YE | | E OF OEATH |
| | JAMES | EDWIN | | SHEPHAR | | EPTEN | | 19 5 | 1 4 | :40 A ^M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. Is | est birthday) YRS. | MONTHS DAYS | HOURS MIN. | 7. DATE | OF BIRTH | | SIRTHPLACE | (State or Foreign |
| | 9a. FACILITY NAME (If not institution, give st | 13 | Thu. | 9b. CITY, TOWN O | P LOCATION OF C | HPI | 4.1741 | 9c. COUNTY | OF DEATH | LAND |
| Œ | JOHNS HOPKINS | | | BALTIM | | ZEATT | | July Cooking | VIA | |
| DIRECTOR | RESIDENCE OF DECEDENT | HOSPITAL | | DALITE | OKE | | | N/H | | |
| H | 10a. STATE 10b. COUNTY | 5 00 | 10c. CIT | Y, TOWN OR LOCATI | 11 - 1 1 | | | 10d. INSIDE CITY LIMITS? | | |
| | 1 IARYLAND HARTORD | | | 711KW | ZIP CODE | | | 10g. CITIZEN | | YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 4193 NORRISI | 8-00 | | 101. | 0.11 | | | iog. Citizen | C C | OUNTRY |
| N. | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. A | RMED | 13. WAS DECI | ENDENT OF HISP | ANIC ORIGIN | 1? (Specify Yes | or No.— 14. | RACE - Am | nerican Indian, |
| | 1 Never Married 2 Married | FORCES? 1 YES 2 K | NO | If yes, spe | 250 NO Spec | can, Puerto | | | Black, White Specify: | n, atc. |
| ВУ | 3 Widowed 4 Divorced | | | 1 | | | | | HW | 115 |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) { | Give kind of | Work done during mos | | - | ORTH | BUSINESS/INDUSTRY H HARFORD | | |
| | Elementary/Secondary (0-12) | Coflege (1-4 or 5+) | to. Do NOT u | ise retired.) | | | 1000 | | Hool | |
| JW | 17. FATHER'S NAME (First, Middle, Lest) | 131 | 100 | 5011 | 16. MOTHER'S N | IAME (First) | Middle Maiden | | 11002 | |
| | | J. CRAKAZHE | IR | | VALS | R. 5 | HAT | HIT | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street ar | nd Number or Rura | I Route Num | ber, City or Town | n, State, Zip Coo | ie) | 21160 |
| 임 | MR+MRS. REGGIED | SHERHARD, JT. | 419 | 3 NORR | Lisvill | 216 | I OA | WHITS | HAU | L. MARY AND |
| | 20a. METHOD OF DISPOSITION Burial 2 Cremation 3 Rame A Donation 5 Other (Specify) | 205 81 4 65 | E AND DATE | OF DISPOSITION (Nai | 130 11 0 | DAT | E 20c. LO | CATION - CHY | or Town, St | 11/200 |
| | 21. SIGNATURE OF FUNERAL SERVICE LA | | -MI | 7 111 | D ADDRESS OF F | 100 | = NH2. | 21112 | 711 | IN LAID |
| | 100 | .) | | EVAN | SCHAI | bet o | F Corti | -62 | | |
| | 23. PART I. Enter the diseases, or o | constitutions that caused the | deeth Do | not enter the mor | de of dylan ev | 150A | dlac or mani | 200 | ium | Approximate |
| | shock, or heart failure. | List only one cause on each lin | ne. | not anter the mor | ua or uying, ac | icii as caii | diac of Teapi | ratory arreat | | Interval Between Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition | Multiple T | - | | | | | | | Onset and Deeth |
| | resulting in deeth) | e. DUE TO OR AS A CONS | EQUENCE C | OF): | | | | | | |
| z | | h | U | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONS | EOUENCE C | OF): | | | | | | |
| CA | cause, Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | | |
| ᇤ | thet initieted eventa reaulting in death) LAST | DUE TO (OR AS A CONS | EDUENCE |)F): | | | | | İ | |
| CEF | | d | | | | | | | | |
| 1 1 | PART II. Other algolificent condition | a contributing to deeth but not | t resulting | in the underlying | g cause given I | n Part I. | 24s, WAS AN PERFOR | | | AUTOPSY FINDINGS ABLE PRIOR TO |
| MEDICAL | | | | | | | 1 TYES 2 | NO | OF DE | PLETION OF CAUSE EATH? |
| | | | | | f | | | | 1 🗆 | YES 2 MO |
| SICIAN: | DID TOBACCO USE CONT | | | ES LI NO LE | UNCERTA | IN L | | | | |
| CC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | Les II | | | | | |
| PHYS | 1 X YES 2 NO | No Inpetiant 2 ER/Outpetiant 28s. DATE OF INJURY | 28b. Til | 4 Nursing Hom | | _ | | NJURY OCCUR | ED | |
| | 1 Natural 5 Pending | (Month, Day, Year) | 140 | | RK? | ped | estriar | 1 stru | ck by | car |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28s. PLACE OF INJURY — At I | home, tarm, | struct, factory, office | 0 | 281, LOC | CATION (Street | and Number or I | | 0 // |
| TED | 4 Homicide determined | building, etc. (Specify) | stre | et | | Whi | or Town, State) | Norris | ville do | Krad |
| COMPLET | 29a. CERTIFIER (Check only | ICIAN: To the best of my knowledge, | death occur | red at the time, data | and place, and d | | use(a) and me | nner as stated. | | |
| OM | 000) | ER: On the basis of examination and/o | or investigati | ion, in my opinion, d | eath occured at ti | he time, det | a and place, ar | d due to the c | euse(s) and | manner as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | RIAA | | | 29c. LICENSE N | UMBER | | 29d, DATE SI | GNED (Mont | h, Day, Year) |
| TO B | Denni | of Chiote m |) | | 0.C. | M.E. | SEI | TEMBE | ER 3, | 1995 |
| ΙÉΙ | 30. NAME AND ADDRESS OF PERSON WH | COMPLETED CAUSE OF DEATH (IT | TEM 27) (Typ | e Print) | | | | | | |

Penn Street, Baltimore,

30. NAME AND ADDRESS OF PERSON WHO COMPLE Dennis Schute us
31. DATE FILED (Month, Day, Year)

SEP 0 8 1995 Jahr 19

32. REGISTRAR'S SIGNATURE

OHMH-16 Rev 1/89

Maryland

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| _ | HEGISTHAH | _ | CE | HIFIC | AIE U | r DEAI | П | HEG. NO | | | | |
|-------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------|-------------------------------------------------------------|------------------------------------|---------------------------|--------------------------------------------------|----------------------------------------------|-------------------------------------------------------------|-----------------------------|----------------------------------------------|--|
| ! | 1. DECEDENT'S NAME (First, Middle, Last) OUISSIE | LEE SEW | ELL | | | | | | Š 1 | 995 | 3. TIME OF DEATH 9:07 A M | |
| | 4. SOCIAL SECURITY NUMBER 213-60-6670 | | E (In yrs. last | | UNDER 1 YEAR | | 24 HRS. MIN. | 7. DATE OF BIRTH (Month, Day, Year) 8/17/195 | | 8. BIRTHI | PLACE (State or Foreign | |
| ļ | | 9s. FACILITY NAME (If not institution, give street and number) | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY C | | | | | |
| 5 | SETON HILL MA | | | | | LTIMO | | | | N/ | | |
| DINECTO | 10e. STATE 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | MARYLAND 10e. STREET AND NUMBER | N/A | В | BALTIMORE 101. ZIP CODE | | | | T 40 CIT | THEN OF W | 1 X YES 2 NO | | |
| FUNERAL | 438 WATTY COUR | T | | | 101. ZIP CODE 10g. CITIZEN OF WHAT | | | | | HAI COUNTRY? | | |
| 101 | 11. MARITAL STATUS 1 Never Merried 2 Merried 3X Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | 8 2 N | NO If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Blac | | | | | | 14. RACE Black Specif | American Indian, White, etc. | |
| 2 | 15. DECEDENT'S EDUCATION | | | CEDENT'S USL | | | | 16b. KIND OF BU | SINESS/IN | DUSTRY | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12th | | | ve kind of work Do NOT use re sembl | tired.) | | g | Fa | cto | ry | | |
| 2 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTE | HER'S NA | ME (First, Middle, Melder | Sumame) | | | | |
| _ | ALONZA W. JA | | | 111 | | RINE QUI | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | MAILING AD | DRESS (Street | et and Number | or Rural I | Route Number, City or Tov | | | | | | |
| CATHERINE JACKSON 438 WATTY COURT BALTIMO | | | | | | | | BALTIMOR | E, I | MD. | 21201 | |
| | 20s. METHOD OF DISPOSITION 1 | | | | | | | | | | | |
| | 21. SIGNATURE OF UNERAL SERVICE LIC | CENSEE () | 11 | 011 | LER | | DY | CETT & SO Y HEIGHT | | | | |
| CERTIFICATION | | | | | | | | | | | Approximate interval Between Onset and Daath | |
| H | that initiated events resulting in death) LAST | | | | | | | | | | | |
| | PART ii Other significant condition | ne contributing to death | but not r | equiting in t | he underly | dog cause | alven in | Part I 24a WBS AI | AUTORSY | 246 | WERE AUTOPSY FINDINGS | |
| MEDICAL | PERFORMED? 1 YES 2 NO DE | | | | | | | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | | | |
| ž | DID TOBACCO USE CONT | RIBUTE TO CAUSE | | | | | ERTAI | иШ | | | | |
| PHTSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLAC | E OF OEATH (| THER: | ne) | | | | | | |
| 2 | 1 TYES 2 NO | 1 Inpetient 2 ER/O | | | | | esidence | ■ □ Other (Specify) | | 2011250 | | |
| BY PH | 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation | 26s. OATE OF INJUR (Month, Day, Yea | | 28b. TIME O | Y | WORK? YES 2 | NO | 28d. DESCRIBE HOW | INJURY O | CCUMED | | |
| - 1 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJU building, etc. (S | IRY — At ho pecify) | me, ferm, stre | et, factory, o | iffice | | 261. LOCATION (Street City or Town, State | | er or Rural F | loute Number, | |
| COMPLETED | (Orack Oray | ICIAN: To the best of my kn | | | | | | | | |) and manner se stated. | |
| TO BE C | 29b. SIGNATUJE AND TITLE OF CENTIFIE | Lund | 9 | , uu | 4 | 29c. LIC | ENSE NUI | 907/ | 29d. DA | G - | (Month, Dey, Year) 6-91 | |
| - | 38. NAME AND ADDRESS OF PERSON WE R- KLICH AT 31. DATE FILED (Month, Day, Year) | J MD & | 21 | N F | 17A | W S | 7 # | 305 B. | ALT | imi | ORE 21201 | |
| | SEP 0 81995 | 22. REGISTRAR'S SI | Red | .11 | | | | | | | | |



....

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-727 9/19/95 t.t

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | CEF | RTIFIC | ATE OF | DEATH | | EG. NO. | | | | |
|---------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------|--------------------|------------------------------------------------------|------------------------|---------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) STEPHEN | MATTH | IEW | | TARBU | CK | 2. DATE OF SEPT | DEATH DAY | 1995 YEAR | 3. TIME OF DEA 9:00 | Рм | |
| | 4. SOCIAL SECURITY NUMBER 5. SE | | AGE (In yrs. lest b | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF I | | | THPLACE (State or F | | |
| | 009-60-0162 | M 2 □ F | 27 | YRS. MO | NTHS DAYS | HOURS MIN. | June 2 | ry, Year) | 968 N | EW YORK | orwign | |
| OR | 9a. FACILITY NAME (If not institution, give street an 1718 REISTERTO | | | 98 | | 21208 | EATH | | BALTII | | | |
| EG | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, CITY, TOWN OR LOCATION 10 | | | | | | | | | |
| DIRECTOR | MARYLAND BALTIN | 10RE | | | TIMONI | | | | | 1 VES 2 | NO NO | |
| FUNERAL | 100. STREET AND NUMBER | h Rd. | | 101. ZIP CODE 21093 | | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| BY FUN | 11. MARITAL STATUS 1 XXVvvv Married 2 Married F | VER IN U.S. ARME YES 2 100 OR DATES | 2 TO If yea, specify Cuben, Mexican, Pur | | | IIC ORIGIN? (S n, Puerto Rica | ORIGIN? (Specify Yee or No— uerto Rican, etc.) 14. RACE — Black, N Specify: | | | ien, | | |
| | 16. DECEDENT'S EDUCATION | 160 DECE | DENT'S HO | IAL OCCUPATIO | N . | 465 VIII | ID OF BUILD | | HITE | | | |
| COMPLETED | (Specify only highest grade complete Elementary/Secondary (0-12) Coll | (Give | 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| W . | 12 2 Nurse Nursing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) | | | | | | | | | | | |
| | Robert Bruce Starbuck Sally Monroe | | | | | | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | MAILING AD | DRESS (Street or | nd Number or Rural i | | | , State, Zip Code) | | | | |
| 2 | Robert Starbuck | 12: | RI | FD 1 | 3ox 280 | Lyndor | onville, Vermont 05851 | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Buriel 2 Xremation 3 Removal for | 20b. PLACE AN | | DISPOSITION (Na | ne of | DATE 7 | 7. | CATION — City or | Town, State | | | |
| | 4 Donation 5 Other (Spec/ly) | 10/ | Meti | co Cr | ematory | , Inc. | | Ca | tonsvil | le, MD | | |
| | 21. SIGNATURE OF FUNERAL BLYGTI | 28 11 | lary | | Lem | | eral Ho | | | ey Valle MD 2109 | | |
| CERTIFICATION | COCAINE AND NARCOTIC INTOXICATION | | | | | | | | | Onset an | d Death | |
| ERTIFIC | CAUSE (Disease or injury that initiated events reaulting in death) LAST | OUE TO (O | R AS A CONSEQU | CONSEQUENCE OF): | | | | | | | | |
| DICAL C | PERFORMED? AM | | | | | | | | 4b. WERE AUTOPSY AWAILABLE PRIOR COMPLETION OF | R TO | | |
| MED | | | | | | / | | | 0 | OF DEATH? | NO | |
| | DID TOBACCO USE CONTRIBU | TE TO CAU | SE OF DEAT | H YES | □ NO [7 | UNCERTAI | N 🗆 | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | SPITAL: | 26. PLACE | | (Check only one) | | | | | | | |
| YSIC | 1777 | | R/Outpatient: 3 | DOA 4 | THER: | e 5 🗆 Residence | 6 (Xother (S | (pecify) | GAS STA | ATION | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF IN (Month, Day, 9/5/95 | JURY Yeer) | 9:00 | | URY AT RK? 'ES 2\(\) NO | UNKNO | | NJURY OCCURED | | | |
| 8 | 3 Suicide 6 XX Could not be 4 Homicide determined | building, at | | | ferm, street, factory, office 2ef. LOCATION (Street) City or Town, Stent ROOM OF MOBILE STATION 1718 REIST | | | | | | | |
| COMPLET | 299. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 0199 2 MEDICAL EXAMINER: On | | | | | | | | | e(e) end manner ee | stated. | |
| BE C | 296 SIGNATURE AND TITLE OF CERTIFIER | 17 | | | | 29c. LICENSE NU | | | | ED (Month, Day, Yea | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COL | WPLETED CAUSE | OF DEATH (ITEM | 27) (Type, Pr | int) | O.C.M | _ | nore | | 06,199 land 21 | | |
| | 31. DATE FILED (Month, Day, Year) | LECUM 32 AEGISTHAR | Ч | | ani ot. | Leel, I | JOT CTI | IOTE | , rary. | rand 21 | 201 | |
| | SEP 0 81995 | Jalin atte | S SIGNATURE | leth | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

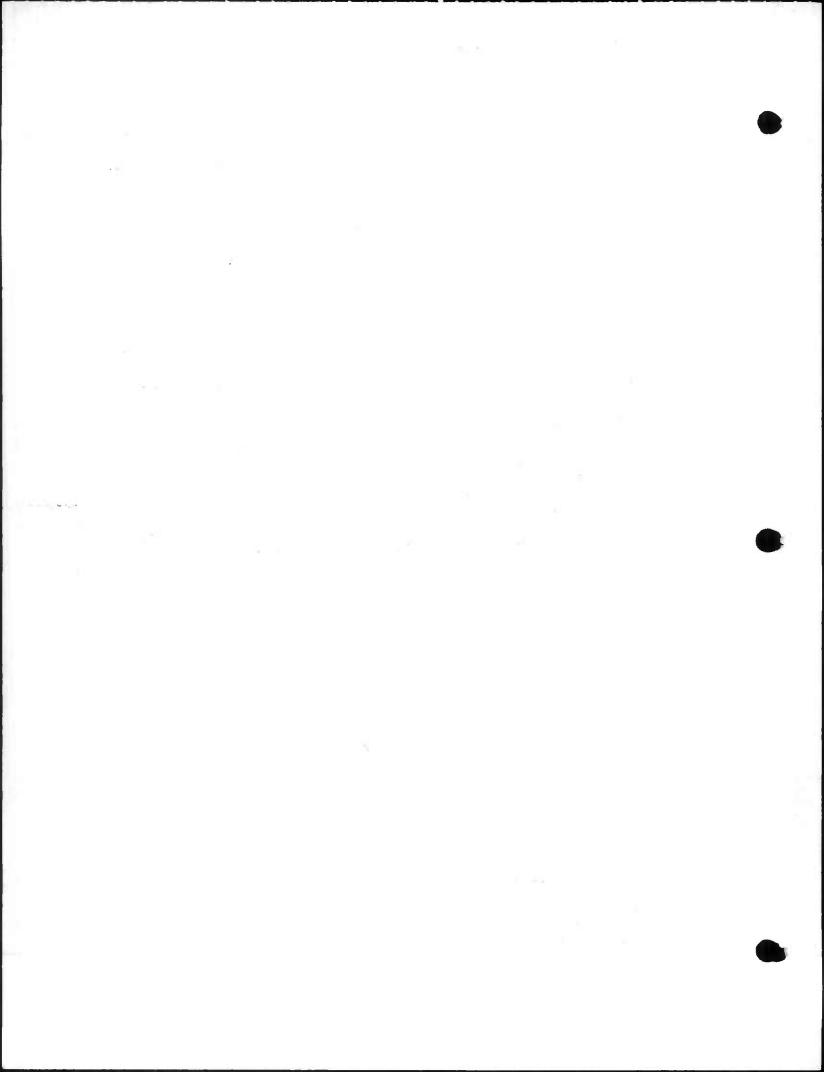
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| SICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifical | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi he filed within 72 hours after death with the State Debt, of Health and Mental Hwelene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other |

| | 1cem20 9-8-90 Fil | mG/Z/ W.H. | Per F/F | (| | | | | | 9 |) 2 | 7308 |
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| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | | MENT OF I | | | | YGIENI EG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF D | EATH DA | γ | YEAR | 3. TIME OF DEATH |
| | Evelyn Magda | | | hae | | | | Septem | ber | | 1995 | 6:30a.м |
| | 100000000000000000000000000000000000000 | 5. SEX 6. A | AGE (In yrs. last bir | | UNDER 1 YEAR | IF UNDER : | 24 HRS. MIN. | 7. DATE OF B (Month, Day | IRTH ; Yber) | | 8. BIRTH Count | IPLACE (State or Foreign (Y) |
| | 9a. FACILITY NAME (If not institution, give stre | X | 88 | | | | | June 4 | , 19 | | | vland |
| 2 | Stella Maris Hospi | | | 9 | Tows | | N OF DE | EATH | | 9c. COU | Balt | imore |
| DINECTOR | 10a. STATE 10b. COUNTY | Baltimore | 10 | De. CITY, T | Towso: | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | | | 10 | f. ZIP CODE | | | | 10g. CIT | IZEN OF V | VHAT COUNTRY? |
| ; | 8300 Alston Road | | | | | | 2 | 21204 | | | USA | |
| ו פוורושר | 11. MARITAL STATUS 1 Never Married 2 Married \${}\$ Widowed 4 Divorced | 12. WAS DECEOENT EVEN FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | YES 2 NO | • | If yes, s | | , Maxica | IIC ORIGIN? (Sp n, Puarto Rican | | or No— | 14. RACI Blact Spec | E — American Indian, c, Whita, etc. |
| | 15. DECEDENT'S EDUCA | | 16a. DECED | ENT'S US | JAL OCCUPATI | ON | | 16b. KINI | OF BUS | INES\$/IN | DUSTRY | |
| | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do | NOT use re | | ost of working | 7 | | | | | |
| | 10 | | Во | ok Ke | eeper | | | Va | lley | Cou | ntry | Club |
| - COIN | 17. FATHER'S NAME (First, Middle, Last) Louis Miller | | | | | | | ME (First, Middle lalena | , Malden S | , | th | |
| 1 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. M. | AILING AO | DRESS (Street | | | Route Number, C | ity or Town | | | |
| 2 | Mrs. Arthur Donova | in | | | effers | | | owson, | | | | 204 |
| | 20a. METHOD OF DISPOSITION 1, Burial 2 Cremation 3 Remov | val from State | 20b. PLACE AND | | | ame of | | OATE | | _ | Cify or To | |
| | 4 Donation 6 Other (Specify) | 7/ | Holy R | edeer | ner Cer | | | 17 | Ва | ltim | ore | Maryland |
| | 21. SIGNATURE OF FUNDIÓN. SERVICE LICE | 1 Deck | É | | 1 | Towsor | n Fu | neral | | | | 050 York Rd |
| | 23. PART I. Enter the diseases, or on ahook, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) a. | Arterio | used the death on each line. Sdero AS A CONSEQUE | tic | | | | | | | | Approximate interval Between Onaet and Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| | | | | | | | | PERFORI | | 24b | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| | DID TODA GGO LIGHT GOVERN | | | | | _ | | <u>-</u> | | | | 1 TES 2 NO |
| Ì | DID TOBACCO USE CONTRI | BUIE 10 CAUSE | | | | UNCE | RTAIN | 1)(1) | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 CONTRIBUTE TO CAUSE OF DEATH (Check only one) 1 OTHER: 1 Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input Input | | | | | | | | | | | | |
| | 27. MANNER OF DEATH | 28s. OATE OF INJU | IRY 28 | b. TIME O | F 28c. IN. | 10 5 ∐ Rea | Hdence | 8 Other (Spe 28d. DESCRIB | | JURY OO | CURED | |
| Netural 5 Pending (Month, Day, Year) INJURY WORK? | | | | | | | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28a. PLACE OF INJ building, atc. (| IURY At home, (Specify) | tarm, stree | ol, factory, offic | :0 | | 281. LOCATION City or Tox | (Street airn, State) | nd Number | or Rural F | loute Number, |
| | | AN: To the best of my k | | | | | | | | | |) and manner as stated. |
| | 29b. \$IGNATURE AND TITLE OF CERTIFIER | | | 9-1011, 11 | y spinost, t | | | | riava, 8/10 | | | |
| d | Kendale 24 | Faulla | reine | 2 | | 29c. LICEN | 56 | 4-2 | | 29d. DAT | 7/ | (Month, Day, Year) |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF | MARYLAND / I | DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE |
|----------|--------------|------------|-----------|-----|--------|----------|
| | CE | RTIFICATE | OF DEAT | 'H | | REG. NO. |

| | 1 - FOR STATE REGISTRAR | | STATE OF MAI | RYLAND / | DEPART | MENT OF I | HEALTH AND | MENTAI | L HYGIEN | E | | |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------|-------------------------------------|-------------|-------------------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | OF DEATH | - | T | 3. TIME OF DEATN |
| | marg | ret | Errot 5. SEX 6. | Jan | 16/41 | 7 | | Sept | | | 995 | 10:15 AMM |
| | | | 5. SEX 6. | AGE (In yrs. last | | | IF UNDER 24 HRS. | 7. DATE | OF BIRTN n, Day, Year) | | 8. BIRTN Country | PLACE (State or Foreign |
| | 218-30-6 | - 0 / | 1 - M 2 - F | 86 | YRS. | ONTHS DAYS | HOURS MIN. | | ber 4 | 1908 | | ric, Canada |
| | 9a. FACILITY NAME (If not in | | | | | | OR LOCATION OF DE | | | | NTY OF DI | |
| DIRECTOR | Union Memor | | pital | | | Baltimo | ore | | | N/A | | |
| EG | RESIDENCE OF DEC | 10b. COUNTY | | | 10c. CITY | TOWN OR LOCA | TION | | | | | 10d, INSIDE CITY |
| 뜸 | Maryland | Baltim | ore | | | eysvil] | | | | | - 1 | LIMITS? |
| | 10e. STREET AND NUMBER | | | | | | I. ZIP CODE | | | 10a CIT | ZEN OF W | 1 YES 2 X NO |
| K | 13801 York | Road | | | | | 21030 | | | Can | | TIAL COORTERT |
| FUNERAL | 11, MARITAL STATUS | | 12. WAS DECEDENT EV | ER IN U.S. ARI | MED | | CENDENT OF HISPAI | NIC ORIGIN | ? (Specify Yea | | | - American Indian, |
| | 1 Never Married 2 | | FORCES? 1 | | 0 | If yes, ap | ecify Cuban, Maxica 2 NO Specifi | in, Puerto F | | | Black | White, etc. |
| ВУ | 3 Widowed 4 Divo | rced | | | | ' | L Marine apacin | , | | | эрвск | White |
| COMPLETED | 15, DEC (Specify onl) | EDENT'S EDUCAT | TION ompleted) | 16a. DEC | EDENT'S U | SUAL OCCUPATION OF MICH MINING MICH MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING MINING M | ON ost of working | 16b. | KIND OF BUS | INESS/INC | DUSTRY | |
| ۳ | Elementary/Secondary (0 | 1-12) | College (1-4 or 5+) | Wo. | Do NOT use | retired.) | • | Ι. | . 1. | | | |
| ₽ F | | | 5+ | NU | rse | | | | Medica | | | |
| | 17. FATHER'S NAME (First, M John | liddle, Last) Mil | kon | Tomb 1. | - | | 16. MOTNER'S NA | | | | | |
| 띪 | 194, INFORMANT'S NAME (1 | | KOII | Tamb1 | | | Lillian | | | | / | |
| ၉ | Carol A. Si | | | 196 | MAILING A | ooness (Street o | imore St | Route Numb | | | | 27.000 |
| | 20a. METHOD OF DISPOSIT | | | | - | | | _ | | | | 21202 |
| | 1 Burial 2 Cremetic | n 3 🗆 Removi | al from State | cemetery, cren | ND DATE OF natory or othe | disposition (Ne r plece) Cremat | eme of | OATE | | | City or Ton | |
| | 21. SIGNATURE OF FUNERA | | ISSE | Green | nount | | OTY ND ADDRESS OF FA | 9// | Ba. | Ltim | ore, | Maryland |
| | > Tower | 1 | 7112 | | | Mitch | ell-Wied | efelo | 1 Home | . In | 2. | |
| _ | Juli | 1.0 | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | | | 6500 | York Roa | d Bal | ltimore | e. M | arvla | and 21212 |
| | 23. PART I. Entar tha d ahock, or h | iseasea, or coi aart fallure. Lie | mplicationa that ca at only ona cause | used the dat on each line. | ith. Do no | enter the mo | da of dying, suc | h aa card | liac or reaple | atory an | reat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Fir | nai | 0 / | | , | - | , (| | | | | Onset and Death |
| | disease or condition resulting in death) | → a | ACUT OUE TO (OR | e RE | nal | Fa | ilure | | | | | 48 hours |
| | | | | | UENCE OF): | | | | | | | |
| CERTIFICATION | Sequentially list conditi | | Jepsi's | AS A CONSEQ | HENCE OF | | | | | | | 2 weeks |
| Ž I | if any, leading to imme- cause. Enter UNDERLY | | 552 10 (61. | AS A CONSEQ | DENCE OF J. | | | | | | | |
| 프 | CAUSE (Disease or Injuthat initiated events | ry C | DUE TO (OR | AS A CONSEO | UENCE OF): | | | | | | - | + |
| F | resulting in death) LAS | T | | | | | | | | | | ! |
| 2 | DARW II ON I III | | | | | | | | | | | |
| <u> </u> | PART II. Other eignifica | 11 | contributing to das | ith but not re | aulting in | tha underlyin | g cause givan in | Part I. | 24s. WAS AN A PERFORI | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | - Coagul | opertny | | | | | | _ [| 1 _ YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? |
| ž | | | | | | | | _ | | | | 1 TYES 2 KNO |
| ÿ. | DID TOBACCO U | | BUTE TO CAUS | | | | . UNCERTAIN | N 🗆 | | | | |
| 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: | | | | | | | | | | _ | | |
| ე ∥ | 1 TYES 2 NO | 1 | Inpatient 2 ER | | | | e 5 🗆 Residence | | | | | |
| IASIC | AT MANNER OF DEATH | | (Month, Day, Y | DRY bar) | 26b. TIME (| Y WO | URY AT | 28d. OE\$ | CRIBE HOW IN | JURY OC | CURED | |
| | 27. MANNER OF DEATN | Pendina | | | | M 1 1 | YES 2 NO | | | | | |
| BY PHYSICIAN: MEDIC | 1 Netural 5 2 Accident | Pending Investigation | 20a BLACE OF IN | HIPW As be- | 4- | V 4 V 40 | | | | | | |
| À | 1 Netural 5 2 Accident 3 Suicide 6 | | 28e. PLACE OF IN. building, etc. | JURY — At hon (Specify) | ne, farm, stre | et, factory, offic | • | 281. LOCA City o | ATION (Street el or Town, State) | nd Number | or Rural Re | oute Number, |
| À | 1 Netural 5 2 Accident 3 Suicide 6 4 Nomicide | Investigation Could not be determined | building, etc. | (Specify) | | | | City o | or Town, State) | | | oute Number, |
| À | 1 Netural 5 2 Accident 3 Suicide 6 4 Nomicide 29a. CERTIFIER (Check only 1) | Investigation Could not be detarmined | AN: To the best of my | (Specify) knowledge, dea | th occurred | at the time, date | and place, and dua | City of | or Town, State) | ver as stat | ed. | |
| | 1 Netural 5 2 Accident 3 Suicide 6 4 Nomicide 29s. CERTIFIER (Check only one) 2 MEDI | Investigation Could not be determined IFYING PNYSICIA CAL EXAMINER: | AN: To the best of my | (Specify) knowledge, dea | th occurred | at the time, date | and place, and dua | to the caustime, date | se(s) and manuand place, and | ver as stat | ed. | end manner as stated. |
| E COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Nomicide 29a. CERTIFIER (Check only 1) | Investigation Could not be determined IFYING PNYSICIA CAL EXAMINER: | AN: To the best of my l | (Specify) knowledge, dea | th occurred | at the time, date | and place, and dua | to the caustime, date | se(e) and manuand place, and | due to th | ed. e cause(s) E SIGNED | end manner as stated. Month, Day, Year) |
| COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Nomicide 29a. CERTIFIER (Check only one) 2 MEDI 29b. SIGNATURE AND TITLE | Could not be determined IFYING PNYSICIA CAL EXAMINER: OF CERTIFIED | AN: To the best of my to On the basis of examination | (Specify) knowledge, dea | th occurred | et the time, dete in my opinion, d | and place, and dua | to the caustime, date | se(s) and manuand place, and | due to th | ed. e cause(s) E SIGNED | end manner as stated. |
| BE COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Nomicide 29s. CERTIFIER (Check only one) 2 MEDI | Investigation Could not be determined IFYING PNYSICIA CAL EXAMINER: OF CERTIFIED PERSON WNO CO | AN: To the best of my I On the basis of exami | (Specify) knowledge, dearnation and/or in | th occurred evestigation, | at the time, date In my opinion, d | and place, and dua eath occured at the 29c. LICENSE NUM Resident | to the cause time, date | se(a) and manual place, and A4 3874 | due to th | ed. e cause(s) E SIGNED | end manner as stated. Month, Day, Year) |
| BE COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Nornicide 29e. CERTIFIER (Check only one) 2 MEDI 29b. SIGNATURE AND TITLE MUCHAL 30. NAME AND ADDRESS OF | Investigation Could not be determined IFYING PNYSICIA CAL EXAMINER: OF CERTIFIED PERSON WNO C | AN: To the best of my I On the basis of exami COMPLETED CAUSE O | knowledge, deannation and/or in | th occurred | at the time, date In my opinion, d | and place, and dua | to the cause time, date | se(e) and manuand place, and | due to the | ed. e cause(s) E SIGNED | end manner as stated. Month, Day, Year) |
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| DIVISION OF VITAL | HOSPITAL OR ATTENDING PHYSICIAN TH |
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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAI CERTIF | RTMENT OF H | IEALTH AND DEATH | | YGIENE EG. NO. | | |
|--------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------|-----------------------------|----------------------------------------------------|------------------------------|------------------------------------------|---------------------------------------------|------------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | PARIL | URLOC | k | | 2. DATE OF C | DAY | YEAR 3. | TIME OF DEATH |
| Pi | | 4. SOCIAL SECURITY NUMBER 217164463 | 1 M 2 NF 7 | (In yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF B | нятн | 8. BIRTHPL. Country) | ACE (State or Foreign |
| , 2, 3 should | ECTOR | 90. FACILITY NAME (If not institution, give str Good Samaritar RESIDENCE OF DECEDENT | | | 96. CITY, TOWN C | PR LOCATION OF E | DEATH | | V/A | |
| if. Pages 1, | DIREC | 10e. STATE 10b. COUNTY | timore | 10c. Cl | PARKVI | | | | | d, INSIDE CITY LIMITS? YES 2 NO |
| an. ransit permit. | FUNERAL | 1809 COBOUR | | 2 | | 2123 | 4 | 10g. CITIZ | USA | T COUNTRY? |
| 5-0020 ding physician. | B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR O. | 2 NO | If yes, sp | ENDENT OF HISPA ecity Cyben, Maxic 2 NO Spec | an, Puerto Rican | | 14. RACE — Black, W Specify: W H1" | American Indien, //hite, etc. |
| MARYLAND 21215-0020 retained by the hospital or attending physics 5 should be detached for use as the bunial notified at once. | LETED | 15. DECEOENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | (Give kind of life. Do NOT u | - | | | of Business/Indi | | |
| rLAND 2 y the hospital be detached to at once. | COMPL | 17. FATHER'S NAME (First Middle, Last) | 15:05:06:50 | Micro | riming | | AME (First, Middle | , Maiden Surname) | raic | .e |
| MARYI retained by 5 should be notified at | TO BE | 19a, INFORMANT'S NAME (Type/Print) | NS PERGER RLOCK | 19b. MAILIN | G ADDRESS (Street a | 0 10 | Route Number, Co | ity or Town, State, Zip | Code) | 21234 |
| Page Page | | 20a. METHOD OF DISPOSITION PR Burlel 2 Cremetton 3 Remort | 206 | netery, crematory or | | 1 000 | OATE Q-II | 20c. LOCATION — C | I IPO | 0 |
| AL.7 death. funer | | 21. SIGNATURE OF FUNERAL SERVICE LICE | INSEE 3 | 1-10HU, | 22. NAME AN SVA | ID ADORESS OF A | ACILITY OF | Jenoris | ジロ,! よ よ よ よ よ | 'IRRYLAGO |
| within 24 hours aft holetely filled in by cremation, or remo | | 23. PART I. Enter the diseases, or co shock, or heart fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) | interpolation of the cause on e my E-LOFI OUE TO (OR AS A | ach line. | not enter the mo | de of dying, su | ch as cardiac | or respiratory arre | est, | Approximate interval Between Onset and Death |
| P.O. BOX 68 th certificate be execute ending physician and co i Hygiene prior to buria or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| that the ed by the th and M and inju | MEDICAL C | PART II. Other algnificant conditions SUBACUTE CER | contributing to death b | out not resulting | in the underlying | cause given in | | WAS AN AUTOPSY PERFORMED? YES 2 NO | AM CO | RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| ITAL RECC 1: The law requires cate has been signe State Dept. of Heatit item 23 shows | CIAN: M | DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE OF DEA | ES NO I | UNCERTAI | NE | | 1 [| YES 2 NO |
| CERTIFICAN: | PHYSICIAN: | 1 TYES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Outp 28e. OATE OF INJURY (Month, Day, Year) | 28b, TH | | | | edfy) E HOW INJURY OCC | URED | |
| After death | ED BY | 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | — A1 home, ferm, | M 1 7 | ES 2 NO | 261. LOCATION City or Tox | | and Number or Rural Route Number, | |
| 물 보지 == | COMPLET | | IAN: To the best of my knowl | | | | | | | d manner as stated. |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER MMMMW | w, | mo | | 29c. LICENSE NU | MBER 17 | 29d. DATE | SIGNED (MO | 7, 1995 |
| 8 | - | 30. NAME AND ADDRESS OF PRISON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type L-RAVE | N BUZ | BALI | v., mo | 21239 | | |
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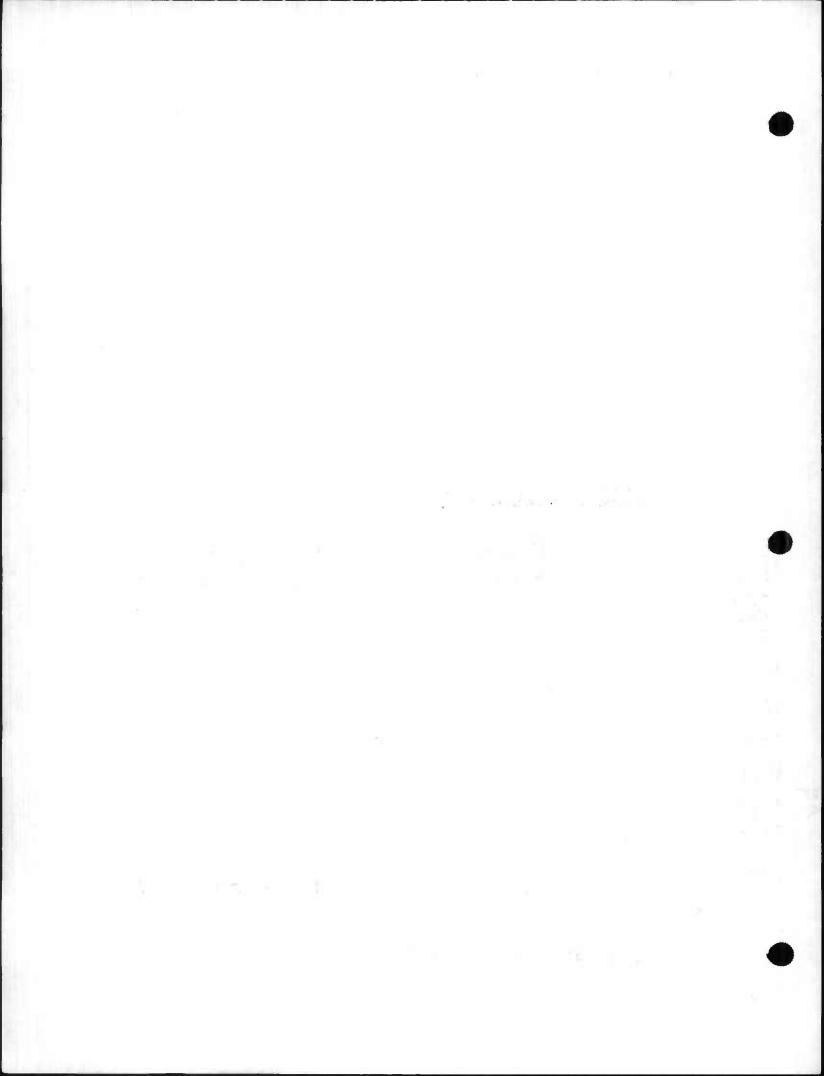
FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. OECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR September 7,1995 Robert F. Vankirk unknown 4. SOCIAL SECURITY NUMBER 8. AGE (in yrs. last birthday) 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 73 213-18-3839 1 😾 M 2 🗌 F YRS. August 5, 1922 iges 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR 2251 Cedley Street Baltimore City N/A RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD N/A Baltimore City 1XX ES 2 NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 2251 Cedley Street U.S.A. 21230 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 15 TYPES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married Nerried Specify:White 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Navy, WWII, 1942-1945 COMPLETED 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 8th N/A Machine Operator MD Glass Company 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surneme) 16 George Vankirk Alice Granger BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mae J. Lindemann 2944 Bero Road, Baltimore, MD 9 20b. PLACE ANO OATE OF DISPOSITION (Name 20c. LOCATION -- City or Town, State must Green Mount Crematory, September 11, 1995, Baltimore City 21, SIGNATURE OF FUNERAL BERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Charles L. Stevens Funeral Home, Inc 1501 E. Fort Avenue, Baltimore, MD 21230 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart fallure. List only one ceuse on each line. interval Between **Onset and Death** IMMEDIATE CAUSE (Final the disease or condition resulting in death) event. traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Inlury, (PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY MEDICAL MAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TYES TO NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) ltem . HOSPITAL DR ATTENDING PHYSICIAN: The this certificate I with the State HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 NO 4 ☐ Nursing Nome 5 ☐ Stesidence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, OFSCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death w BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 28 4 Homicide Hem 29a. CERTIFIER | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATUM AND TITLE OF CENTURIERS BE 26156 195 9/06 2 PERSON WNO COMPLETEO CAUSE OF DEATN (ITEM 27) (Type, Print) 4000 Annapolis Road Baltimore, MD 21227 Calderon, M.D. Jorge 32. REGISTRAR'S, SIGNATURE

Jelia d'Eudean Realell

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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| PITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, | DIRECT | hours a |
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| THE H | THE R | he filed within 72 hours after death with the State Dept, of Health and |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH VERNACCHIO EVELYN SEP T 15 PM 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. 1 M 2 P YDS OCT. 2, 220-07-0539 MARYLAND 9e. FACILITY NAME (If not institution, give street and number, 9h. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 423 SOUTH SMALLWOOD STREET BALTIMORE CITY DIRECTOR BALTIMORE RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY 10e. STATE 10b. COUNTY MARYLAND BALTIMORE CITY BALTIMROE 1 X YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 10a. STREET AND NUMBER FUNERAL 423 SOUTH SMALLWOOD STREET 21223 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 TES 2 X NO Specify: BY 3 Widowed 4 Divorced WHITE 18e. DECEDENT'S USUAL OCCUPATION

(Glue kind of work done during most of working ED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade or (Give kind of work done during life. Do NOT use retired.) COMPLET Elemantary/Secondary (0-12) College (1-4 or 5 +) 10TH GRADE LABORER HOSPITAL LAUNDRY 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPH AMEND ALINE SHOCKNEY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 SOUTH SMALLWOOD STREET - BALTIMORE, MD VINCENT J. VERNACCHIO 21223 20s. METHOD OF DISPOSITION
1 A Buriel 2 Cremetton 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 4 Donation 6 Other (Specify) LOUDON PARK CEMETERY 9/5 BALTIMORE 21. SIGNATURE OF FUSIENCE. SERVICE-CIDENSE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE. MD 21229 23. PART I. Entar the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Interval Between Onset and Death shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final disesse or condition ultistroko disease with demanti resulting in death) terroscloratic corebravasculor de CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury QUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERF AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25, WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: raing Home 5 Theeldence 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 Other (Specify) 27, MANNES OF DEATH 26a, DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF

1 Netural 5 Pending 2 Accident Investigation

6 Could not be

determined

28c. INJURY AT WORK? INJURY 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the beels of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D01786

allager, wrence NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

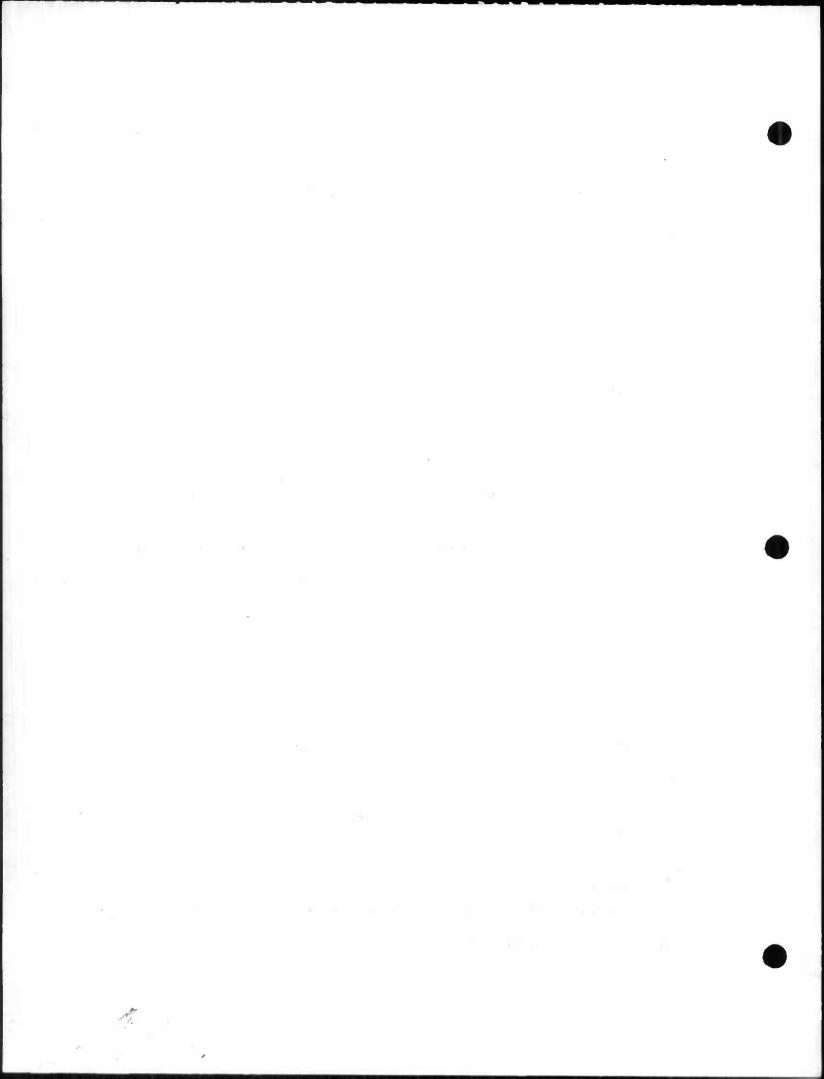
LAURENCE RGALLAGER, MD, 3455 WILKENS AVE, BALTIMORE, MARYLAND

31. DATE FILEO (Month, Day, Year)

3 Suicide

4 Homicide

32. REGIŞTRAR'S SIGNATURE divolen



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| . 5 | FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
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| | REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |
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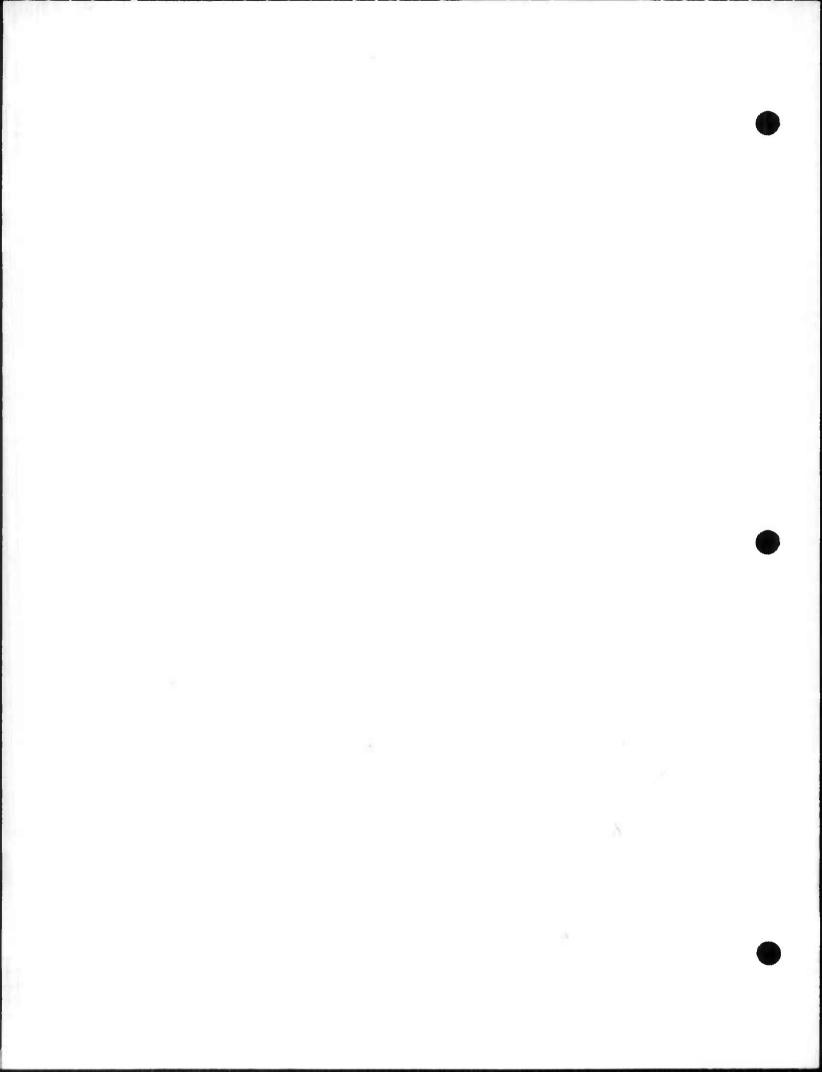
| | 1 - STATE REGISTRAR | STATE OF N | | ERTIF | ICAT | E OF | DEATH | MENIA | REG. NO | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last, | | | | | | | 2. DATE | OF DEATH | AY | YEAR | 3. TIME OF DEATH |
| | HELEN R. VA | AN HORNE | E | | | | | SEP | | | 995 | 3:00 A. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | | MONTHS | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Mont) | OF BIRTH n, Day, Year) | | Counti | |
| | 215-40-7710 | 1 M 2X F | 84 | YRS. | | | | | . 18,19 | | | ŃNSYLVANIA |
| | 88. FACILITY NAME (If not institution, give 1818 WOODSIDE AV | ŕ | | | | V, TOWN C | ORPE | EATH | | | ALTI | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUN | TY | | 10c. C/T | ry. TOWN | OR LOCAT | ION | | | | _ | 10d. INSIDE CITY |
| | MARYLAND BAL' | TIMORE | | | HAL | ЕТНО | RPE | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | 1 | | 101 | . ZIP CODE | | | 10g. Ci1 | TIZEN OF | VHAT COUNTRY? |
| | 1818 WOODSIDE A | VENUE | | | | | 2122 | .7 | | | U. | S.A. |
| 2 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Otvorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 27 | | 13. | If yee, sp | ENDENT OF NISPAN scify Cuban, Maxica 2 X NO Specify | n. Puerto I | | or No- | | E — American Indian, k, Whita, atc. |
| 1 | 15. DECEDENT'S ED (Specify only highest grad | | (0 | ECEDENT'S | work done | during mo | ON st of working | 16b | KIND OF BU | SINESS/IN | DUSTRY | |
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| THE STATE OF | 17, FATHER'S NAME (First, Middle, Last) | | 1 | TOMEN | AKEK | • | 18. MOTNER'S NA | | | | | |
| S C | HENRY SHAFFER | - | | | | | NELLIE | P00 | RBAUGH | [| | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) MR. MARSHALL W. | VAN HORN | | | | | E AVENUE | | | | | 21227 |
| | 20e METHOD OF DISPOSITION 1 X Burlel 2 Crematton 3 Re 4 Donatton 5 Other (Specify) | movat from State | 206. PLACE | | | | IAL PARK | DAT | | RTDG | - City or To | own, Stata |
| | 21. SIGNATURE OF FUNEJIAL SERVICE I | JCENSEE 1 | _ TILIADO | JWKID | - | | O FUNERA | | | | 113 | |
| | 10/my 1 | 1 tai | lma | 5 | | | | | | | MORE | MD 21229 |
| CALCON | 23. PART I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | | | |
| 2 | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDIN | | | | | | | | | . WERE AUTOPSY FINDINGS | | |
| 200 | Comments and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | | | PERFORMED? | | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| MED | 1 YES 2 NO | | | | | | | | | | | |
| AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | |
| SICIAN | 25. WAS CASE REPERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input Int 2 ER/Outpet Int 3 DOA 4 Nursing Name 5 Sesidence 6 Other (Specify) | | | | | | | | | | | |
| THA | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE O | | 28b. TII | | 28c. IN. | JURY AT DRK? | | SCRIBE NOW | INJURY O | CCURED | |
| 2 Accident Investigation 3 Sutcide 8 Could not be 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | CATION (Street or Town, State | | er or Rural | Route Number, | | |
| MPLEIE | 4 Nomicide determined | /SICIAN: To the best of | of my knowladge. | death occur | red at the | time date | and place and dur | to the ca | use(s) and ma | nner sa si | ated. | |
| 2 2 2 | (Criedit Orny | (Check only Time Partician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| ם | 29b. SIGNATURE AND TITLE OF CERTIF | J/Car | h | | | | 29c. LICENSE NU | MBER 4 9 5 | -1 | 29d. D/ | 9 - | 7 - G (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON N | | | | | | | | | | | |
| | DR. EDMUND P. TK 31. DATE FILED (Month, Day, Year) | ACZUK - 4 | | | K RO | AD - | SUITE 10 | 00 – | CATON | SVIL | LE, N | ID 21228 |
| | 31. DATE FILED (MONTH, Day, Year) SEP 0 8 1995 Jeli Division Coulds | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital or attending physician. |
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| TO THE FUNESTUDE: After this celembar been signed by the autenoing physician and completely filled in by the superation of the property of the filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR | STATE O | E MADVI AND | DEDADTMENT | OF HEALTH AND | MENTAL HYGIENE |
|-----|-------|---------|-------------|------------|---------------|----------------|
| 1 . | STATE | SIMIL U | MANTLAND | DEPARTMENT | UP HEALIH AND | MENIAL HYGIENE |

| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | F | REG. NO. | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------|---------------------------------------------------------|------------------------------------------|-------------------------------------------|--------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | | MEAG | 3. TIME OF DEATH |
| | PAULINE WENDEL | | | | | | 804 | 9:50 Pm | |
| | THE RESERVE OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF T | | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF I | | 8. BIRT | HPLACE (State or Foreign |
| | 311-30-9469 | 1 □ M 2 🔀 F 99 | YRS. | ONTHS DAYS | HOURS MIN. | | 3-1895 | | yland |
| - | 9e. FACILITY NAME (If not institution, give stree | | | | OR LOCATION OF DE | | | 9c. COUNTY OF | DEATH |
| DIRECTOR | PICKERSGILL RET | FIREMENT C | OMMUN. | Tows | on, Md. | | | Balt: | imore |
| ᇤ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c CITY | TOWN OR LOCA | TION | | | | |
| E | Maryland Balti | | | arion . | | | 10d. INSIDE CITY LIMITS? | | |
| | 10a. STREET AND NUMBER | TIDLE | Tows | | of, ZIP CODE | | I. | 10- OFFISEN OF | 1 YES 2 NO |
| FUNERAL | 615 Chestnut Ave. | | | 1 " | 1 7 1 1 1 1 1 1 | | - 1 | _ | |
| ž l | | 12 WAS DECEDENT EVED IN | U.S. ARMED | 21204 3. ARMED 13. WAS DECEMBENT OF HISPANII | | | anathi Van si | U.S.A | E — American Indian, |
| | 1 Never Married 2 Merried | FORCES? 1 YES | 2 NO | If yes, s | pecify Cuben, Mexica | n, Puerto Ricar | n, etc.) | Blee | ck, White, atc. |
| BY | 3 🔀 Widowed 4 🗌 Divorced | " 'LO, ONE WINTON DA | | 1 | S 2 NO Specify | γ: | | Wh: | ite |
| | 15. DECEDENT'S EDUCAT (Specify only highest grade col | FION moletecil | 16a. DECEDENT'S US (Give kind of wor | BUAL OCCUPAT | ON | 16b. KIN | D OF BUSIN | ESS/INDUSTRY | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | ost or working | | | | |
| M M | 12 yrs | | Secreta | ry | | 5 | Safewa | ay | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | | e, Maiden Su | rname) | |
| B | unknown | De | icke | | unl | known | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | end Number or Rural F | | | | |
| | Pickersgill Home | | 615 Ch | estnut | Ave. Tow | vson, M | ld. 21 | 204 | |
| | 20a. METHOD OF DISPOSITION 1 Specific 2 Cremetion 3 Remove | el from State ceme | PLACE AND DATE OF elery crematory of other | r place) | | DATE | DATE 20c. LOCATION — City or Town, State | | |
| | 4 Donation 6 Other (Specify) | P | arkwood C | emeter | | 9-7 | Par | kville | Md. |
| - // | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | | | NO ADDRESS OF FAC | | IIama | Tenan | |
| | 1141 | | | 1050 | rowson Fu York Rd. | Towson | nome, | 21204 | |
| | 23. PART i. Enter the diseases, or con | nplications that caused | the death. Do not | anter the me | ode of dying, auc! | h aa cardiac | or respirat | tory arrest, | Approximate |
| | shock, or heart feilure. List only one ceuse on aech ilna. IMMEDIATE CAUSE (Fine) Onset and Death | | | | | | | | |
| | disease or condition resulting in death) - Congestive heart tailure | | | | | | | | |
| | teauning in death) | DUE TO (OR AS A | CONSEQUENCE OF): | | 12 | | | 2 | |
| Z | immediate cause (Final disease or condition resulting in death) s. Congestive heart failure Due to (or is a consequence of): Atherosclerofic Candido Vascular Disease | | | | | | | | |
| CERTIFICATION | if any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| 3 | CAUSE (Disease or injury C. | | | | | | | | |
| | that initiated events resulting in death) LAST | | | | | | | | |
| 5 | d | | | | | | | | |
| | PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS | | | | | | | | |
| DICAL | Decemenative Tout disease PERFORMED? MALL | | | | | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| MED | Defend tion DE DEATH? | | | | | | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | 1 TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | |
| SIC | | IOSPITAL: | etlent 3 DOA 4 | THER: | ne 5 🗆 Residence | 8 Oth-1/01 | | | |
| Ŧ | 27. MANNER OF DEATH | 28e. DATE OF INJURY | 28b. TIME O | F 28c IN | JURY AT | | | URY OCCURED | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJUR | M 1 D | ORK? YES 2 NO | | | | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | - At home, farm, stre | et, factory, offic | :• | 281. LOCATION (Street and Number or Rural Route Number, | | | Route Number, |
| 핃 | 4 Homicide determined building, etc. (Specify) | | | | | | | | |
| ٦١ | 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. | | | | | | | | |
| COMPLETED | | | | | | | | | e) and manner ee stated. |
| 14 | 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. 29b. SIGNATURE AND JETLE OF SERTIFIER | | | | | | | | |
| BE | M. Hatta | | | D) S | | 2 | 9d. DATE SIGNED | (Month, Day, Year) | |
| 2 | 11 111111111111111111111111111111111111 | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type Pr | int) | - 2- | | | 1/3 | , , , |
| 100 | 30. NAME AND ADDRESS OF PERSON WHO C | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Print) | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO C | 6701 | N. Cha | les | | | | | |
| | GBMC | 6701 1 | N. Chr | les | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO CO | 6701 32, AGGISTRAP'S SIGNA JULY DRUMES | N. Chr | le, | | | | | |



Pages 1, 2, 3 should

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Doris J Wheeler eptember 03 1995 10:05 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year)
APR. 13,1916

8. BIRTHPLACE (State Country)
Maryland 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 1 M 2 X F DAYS HOURS YRS 212-01-3291 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Greater Baltimore Medical Center Towson Baltimore 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A 1X YES 2 NO Baltimore City FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5624 Midwood Avenue 21212 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Ricen, etc.)

1 □ YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 X Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Beautician Beauty Salon 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme, Philip Jacob Mary Adele Soistman Volker BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Joan Kenney-Grempler 2007 Tufton Avenue, Reisterstown, MD. 21136 20e METHOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Moreland Memorial Park 9/7 Carney, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Mitchell-Wiedefeld Home, Inc. 15h 2 6500 York Rd. Baltimore, Maryland 21212 23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition Kespiralory 2 days resulting in death) Chronic Obstructive Lung Disease unknows CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in deeth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 TRINO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \boxtimes PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) I YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending м 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(e) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated. NO NONATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SJGNED/(Month, Day, Year) BE I honde it auda D43936 17 ▶ 9/4/95

THOMAS F. LANSDALE II, M.D. 6565 N. charles St., Baltimore MD 21204 31. DATE FILED (Month, Day, Year) SEP 0 81995

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FOR 1 STATE

| REGISTRAR | | CERTIFIC | ALE OF | DEATH | REG. NO | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------|---------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------|--|--|
| | WIN WE | AKLAND | | | - | 1995 YEAR | 12:12a M | | |
| 4. SOCIAL SECURITY NUMBER 193 10 2672 | 5. SEX 6. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) July 11,1 | 916 Pe | THPLACE (State or Foreign entry) | | |
| 98. FACILITY NAME (# not institution, given 1567 Alconbury I RESIDENCE OF DECEDENT | | 91 | Esse: | OR LOCATION OF D | EATH | Baltimore | | | |
| 10e. STATE 10b. COU | | 10c. CITY, T | OWN OR LOCA | | | 10d. INSIDE CITY LIMITS? 1 YES 2X NO | | | |
| 10e. STREET AND NUMBER | Maryland Baltimore | | | f. ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | | |
| 1567 Alconbury R | oad Apt. "F" | IN HE ADMED | 21221 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify | | | U.S.A. | | | |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 X YES | 2 NO | If yes, sp | | en, Puerto Ricen, etc.) | BI | eck, White, etc. | | |
| 15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12) | | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | done during m | | 16b. KIND OF BU | SINESS/INDUSTRY | | | |
| 10 | | Crane C | perato | r | Stee | l Mill | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Malden | | | | |
| Andrew Weakl | and | | | Ruth | Rhoade | | | | |
| 19a, INFORMANT'S NAME (Type/Print) | | 1 | | | Route Number, City or Tox | | | | |
| Imelda B. Weakla | | | | y Road A | | | yland 21221 | | |
| 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 R | amoval from State | ob. PLACE AND DATE OF I emetery, crematory or other | place) | ame of | -10- | CATION — City or | 1 | | |
| 4 Donation 6 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE | | ARSENS 04 | | 7/ | 1.01 | | MARYIANI | | |
| (Dan J | mentiger | h. | | | uneral Hon Ave. Balti | | aryland 2122 | | |
| IMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentially list conditions, | disease or condition resulting in death) a. Vetastate Drostate Cancer. OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| oue to (or as a consequence of): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST d. | | | | | | | | | |
| PART II. Other algnificant condi | but not reaulting in | the underlying | ng cause given in | Part I. 24a. WAS AP PERFO 1 YES | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. | | | | | | INJURY OCCURED | | | |
| 1 Natural 5 Pending 2 Accident Investigati | | JURY WORK? M 1 YES 2 NO | | | NTION (Street and Number or Rural Route Number, | | | | |
| 3 Suicide 6 Could not be datermined 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26s. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| (Check only | (Check only Chert Principles of the cause(s) and memor as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERT | FIER PARale | atjin | 0 | 19c. LICENSE NI | MBER 9 | 29d, DATE SIG | NED (Month, Day, Year) | | |
| P. A. BALTATZI | WHO COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, P | e Rd. | Svite: | 202. BA | HCto. M | 1.0.2133 | | |
| SEP 0 81995 | 32. REGISTRAR'S SI | GNATURE | | | | | | | |



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WHO COMPLETED CAUSE OF DEATH (ITEM/2) (Type, Print)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH MONTH 3. TIME OF DEATH 7. DATE OF BIRTH (Month, Day, Year) 1:10 IF UNDER 1 YEAR 1 M 2 | F DAYS 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimor YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 2 1 2 15

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married 1 TYES 2 NO 3 Widowed 4 Divorced Specify 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work do life, Do NOT use retire ndary (0-12) College (1-4 or 5 +) Unknown dnio n earnst 17. FATHER'S NAME (First, Middle, Last) John Od 19b. MAILING ADDRESS (St. 0 200. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION uriel 2 Cremation 3 🗆 Palory or other place) ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF Derrick Are Ballo. 1611 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate interval Between shock, or heart failure. List only one on asch lina. **IMMEDIATE CAUSE (Final Onset and Death** disesse or condition_ resulting in death) me musch DUE TO (OR AS A CONSEC Meumoney Sequantially list conditions, DUE TO (OR AS A CO if sny, laading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to geath but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? where 1 TES 2 NO OF DEATH? 124sele 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL 1 YES 2 NO OTHER 1 | Inpatient 2 | ER/Outpatient 3 | DOA rising Home 5 - Residence 6 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural M 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: viedge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2 MEDICAL EXAMINER: On th ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner as stated.

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) 91619

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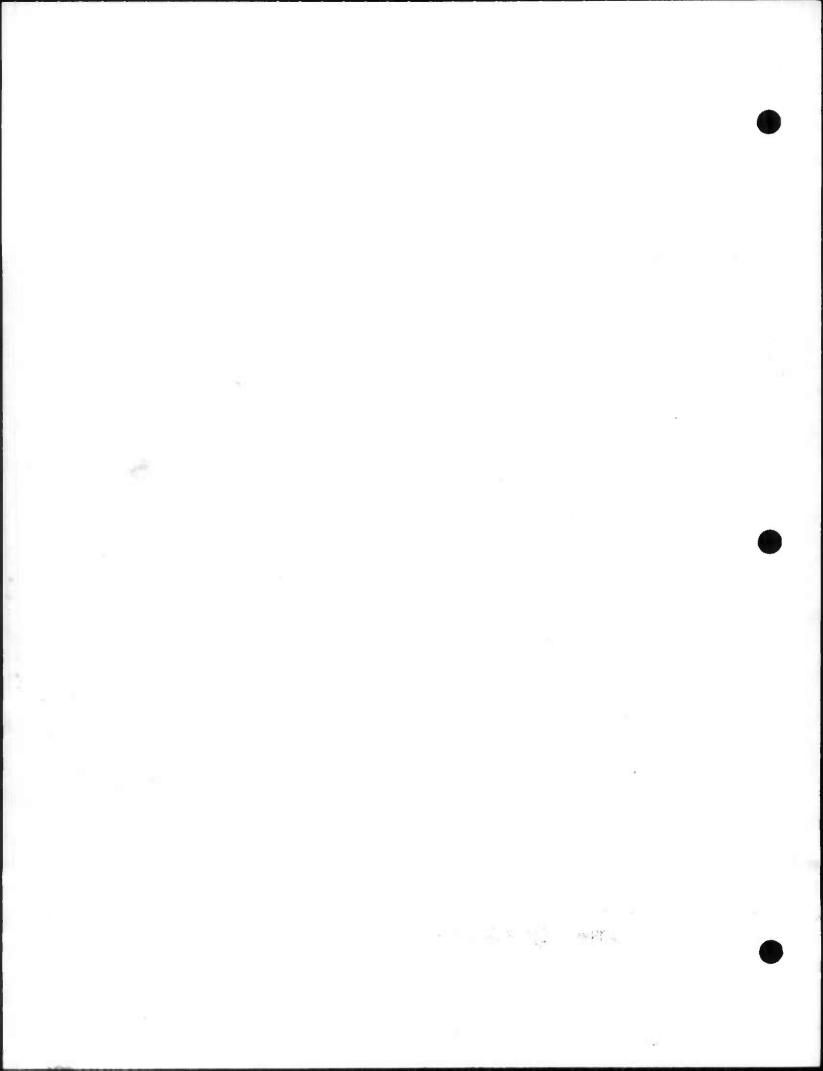
| TO THE FUNEATION. After this criticate has been signed by the attending physician and completely filled in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3. To THE FUNEAL DIRECTOR. After this criticate has been signed by the attending physician and completely filled in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3. The filled within Z hours after death with the State Detr. of Health and Merital Hygiene prior to burial, crimation, or removal. | 84 | DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 |
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| | 1 | 10 THE MOSH UP ALI STANDING PRITISCULAY: THE BAY REQUIRES that the death centificate to execute writing and according to the configuration and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State begin, of Health and Mental Hydrien prior to burial, creation, or removal. |

| OR ATE EGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|-----------------------------------|-------------------------------------------------------------------|----------------------------|
| DENT'S NAME (First, Middle, Last) | 1) 1 1 | 2. DATE OF DEATH |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTMENT CERTIFICATE | | REG. NO. | | | | | | | |
|------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | PAUL W | Hisms | | 2. DATE OF DEATH DAY | SEAR 3. TIME OF DEATH AS STORY M | | | | | | |
| | | 1 X M 2 D F 79 | yrs. Wonths yrs. CITY. | 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. TOWN OR LOCATION OF DEJ | 7. DATE OF BIRTH (Month, Day, Year) 8 - 9 - 1916 ATH 2 1 9c. COUN | BIRTHPLACE (State or Foreign Country) MATYAN ITY OF DEATH | | | | | | |
| DIMECTOR | 106, COUNTY | lington A | 10c. CITY, JOWN O | Allimore R LOCATION | o City | M/A, | | | | | | |
| AL DIR | 10e. STREET AND NUMBER | V/A | BAL | 101. ZIP CODE | 10g. CiTi | IMITS? 1 Z TES 2 NO ZEN OF WHAT COUNTRY? | | | | | | |
| FUNER | 1/36 N/ Lor | | □NO II | f yes, specify Cuban, Mexicar | C ORIGIN? (Specify Yes or No — | 14. RACE — American Indian, Black, White, atc. | | | | | | |
| ED BY | 3 Widowed 4 Divorced 15. DECEDENT'S EDUCA (Specify only highest grade or | IF YES, CIVE WITH OR DATE: ATION Ompleted) 16. | DECEDENT'S USUAL OF Give kind of work done of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of | YES 2 NO Specify. | 16b. KIND OF BUSINESS/IND | Black USTRY | | | | | | |
| COMPLEIED | Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) | College (1-4 or 5+) | 05TA | Service | ME (First, Middle, Melden Surname) | vernment | | | | | | |
| N N | GYONG F. | William | | FRE | ne Hopk | Lins (CODO) | | | | | | |
| 2 | 20. METHOD OF DISPOSITION 1 Burlet 2 Cremetton 3 Remov | | ACE AND DATE OF DISPOS y, crematory or other place) | Helington ITION (Name of | AUR BALL | Cut or Town, State | | | | | | |
| | 21. Skilled OF FUNERAL SERVICE LICE | NSEE CS A | Trison Fe | NAME AND ADDRESS OF FAC | SUSS FUNC | Mills MO. | | | | | | |
| | | emplications that caused the | e desth. Do not enter | the mode of dying, such | n as cerdiec or respiratory arr | Peat, Approximate interval Between Onset and Desth | | | | | | |
| | iMMEDIATE CAUSE (Finsi disease or condition resulting in deeth) | A DUE TO (OR AS A CO | USIS INSEQUENCE OF): | 1 | | 4 ma | | | | | | |
| FICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS CO | DNSEQUENCE OF): | yelomo | > | Lyr | | | | | | |
| CERTIFIC | CAUSE (Disease or injury that initiated events resulting in death) LAST | CAUSE (Disease or injury that initiated events Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| AL | PART II. Other significant conditions Digbetes | | not resulting in the un | derlying ceuse given in | Part i. 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? | | | | | | |
| N: MEDIC | DID TOBACCO USE CONTR | | | | 10 | 1 TYES 2 NO | | | | | | |
| PHYSICIAN: | | 26. HOSPITAL: 1 Inpatient 2 ER/Outpatie | PLACE OF DEATH (Check of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the st | | 6 Other (Specify) | | | | | | | |
| BY PH | 27. MANNER OF DEATH 1 N Netural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OC | CURED | | | | | | |
| ED | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify) | Al home, ferm, street, fact | | 28f. LOCATION (Street and Number City or Town, State) | r or Rural Route Number, | | | | | | |
| COMPLET | Check only | | | | to the cause(a) and manner as startime, date and place, and dua to it | Many and the second | | | | | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEAT | 1 (TEM 27) (Type Print) | 29c. LICENSE NUI | 645 29d. DAT | E SIGNED (Month, Day, Year) | | | | | | |
| | Brian Spa | Y, MD | 6565 N | Chorles | St, 5216, Bel | timore Mod | | | | | | |
| | SEP 0 81995 Ju | li d'audentad | 14 | | | | | | | | | |

and the later to the same

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| - 1 | 1 | 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | | | | | 2. DATE OF DEAT | | | 3. TIME OF DEATH | |
| | | HE | LEN | L. WESKO |) | | | | | | SEPT. 5, 1995 4:20 P M | | | | |
| 1 | | 4. SOCIAL SECURITY NUME | | S. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER t | t YEAR | IF UNDER 24 | $\overline{}$ | 7. DATE OF BIRTH | | S. BIRTH | IPLACE (State or Foreign | |
| | | 203-20-000 |)3 | 1 🗌 M 2 💢 F | 78 | YRS. | монтнв | DAYS | HOURS | MIN. | Month, Day 164 | 1917 | Countr | nnsylvani | |
| pino | - 9 | | | street and number) | | | 96. CITY | TOWN | OR LOCATION | N OF DEA | | | | | |
| 60 80 | Œ | | | | | | | | | | ••• | | | | |
| ci | 8 | RESIDENCE OF DEC | EDENT | JN | | | | 10 | WSON | | | | BAL | TIMORE | |
| Ses | Ĭ, | 10e. STATE | 10b. COUNT | Y | | 10c. CIT | Y, TOWN OF | R LOCA | TION | | 10d. INSIGE CITY | | | | |
| 2 | ā | Md. | B | altimor | е | | Du | ınd | a1k | | | | - 1 | LIMITS? | |
| ermi | 4 | 10e. STREET AND NUMBER | 7 | | | | | 10 | H. ZIP CODE | | | 10g. CITIZ | EN OF V | | |
| isit p | EN I | 7829 Hard | old R | đ. | | | | | 21222 | 2 | | 100 | | | |
| l-trar | 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | NT EVER IN U.S. | N U.S. ARMED 13. WAS DECEMBENT OF HISPANIC C | | | | | OBIGIN? (Specif | You or No | 14 DACE | - American Indian | |
| buri | - 11 | 1 Never Married 2 | Married | | | NO | н | yes, sp | pecify Cuben, | Maxican, | Puerto Rican, etc | .) | | — American Indian, k, White, etc. | |
| | | 3 Widowed 4 Divo | roed | 1 125, 0172 | MAN ON DATES | | '' | ∐ YES | X NO | Specify: | | | | | |
| Se as | 8 | | | | | | | | | | 16b. KIND OF | BUSINESS/INO | | LE | |
| 2 | | | | | +1 | (Give kind of a life. Do NOT us | work done du se retired.) | uring mo | ost of working | | | | | | |
| ped . | 립 | 8th | | | | | | | | | Owi | n Home | | | |
| etac | S | 17. FATHER'S NAME (First, M | iddle, Last) | | | | | | 16. MOTHE | R'S NAMI | E (First, Middle, Ma | iden Sumame) | | | |
| 8 K | | Frank Se | egedy | | | | | | | | 4 | | | | |
| pino Ber | | 19a, INFORMANT'S NAME () | ype/Print) | | | 19b. MAILING | ADDRESS | (Street s | | | | France Chain 7/a | Codel | | |
| 5 | 2 | | | ender | | | | | | | | | | 1222 | |
| 8 9 | | 7029 Harold Rd., Baltimore, Md | | | | | | | | | | _ | | | |
| tor. | | 20s. METHOD QE DISPOSITION 1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cematery, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | | | | | |
| direc | | | | PENGEE | <u> LChe</u> s | sapea | ke C | re | mato | ry (| 9-7-95 | Belt | svi | lle, Md. | |
| m m | | 7700 | A | A | - | | 22. N | A.1 | ND ADDRESS | OF FACI | ury Do Euro | 2 2 2 2 | 100- | 21222 | |
| exa exa | | Mul | less. | Made | - | | 013 | IUI I | W-111 | SILL | on rune | arat u | ome | , INC. | |
| by th | | 23. PART I. Enter tha di | seasea, or | complications the | at caused the | death. Do r | not anter t | the mo | ode of dying | g. such | as cardiac or r | eapiratory arm | at. | Approximata | |
| a or no | | ahock, or he | eert failure. | List only one ceu | use on each II | na. | | | | | | | | intarval Between | |
| | | disease or condition | int | 1 1 = | TNI | | | | | | | | | Onset and Death | |
| | - # | resulting in death) a. Oue TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| | _ # | | | DOE 10 | (ON AS A CONS | SECUENCE OF | r): | | | | | | | | |
| sician and corrior to burial, traumatic en | RTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ior to | F | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| ing physical distriction of the t | 윤 | CAUSE (Disease or Injury | | | | | | | | | | - | | | |
| | Ē | | "y | that initiated eventa OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | ! | |
| tal H | | that initiated eventa | | 00E 10 | (OIT NO A CONS | LOOLIVOL O | <i>r</i> · | | | | | * | | | |
| | ш | that initiated eventa | | d | (OI NO X 00113 | LOGETOE OF | , | | | | | 1 | | | |
| Men Men | 8 | that initiated eventa resulting in death) LAS | 7 | d | | | | Jariyin | g cause,giv | van in Pi | nrt i. 24a, WA | B AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS | |
| d by the att | 8 | that initiated eventa | T condition | d | | | | Jariyin: | g cause giv | van In Pr | T PEF | FORMED? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| ealth ar | ш | that initiated eventa resulting in death) LAS | 7 | d | | | | Jariyin, | g cause giv | van in Pr | T PEF | | 24b. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| en signed b | MEDICAL CE | that initiated eventa resulting in death) LAS | int condition | d. na contributing to Lec(i | death but not | t resulting | In the und | 14 | SPA | UT | PEF 1 O YE | FORMED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| is been signed bept, of Health ar | MEDICAL CE | PART II. Other algnifica | ont condition | d. na contributing to Lec(i | death but not | t resulting | in the und | M 10 [| SPA | UT | PEF 1 O YE | FORMED? | 24b. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
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| this certificate has been signed by with the State Dept, of Health ar rked, or Item 23 shows any | PHYSICIAN: MEDICAL CE | that initiated eventa resulting in death) LAS' PART II. Other algnifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 | ont condition | RIBUTE TO CA | death but not | ATH YEACE OF DEAT | In the und | IO [_ nly one) : ing Hom 28c. INJ WO | UNCE | RTAIN dence 6 | PEF 1 VE | FORMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
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SOCIAL SECURITY NUMBER S. SEX S. AGE (in yrz. lest bethology F. MOSEN TAME of perity TAME (if not institution, pive street and number) Se. CITY, TOWN ON LOCATION OF DEATH Se. COUNTY OF 0 MANOR CARE TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON TOWSON T | |



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| DIVISION OF VITAL RECORDS, | OD ATTENDING DHVCICIAR |
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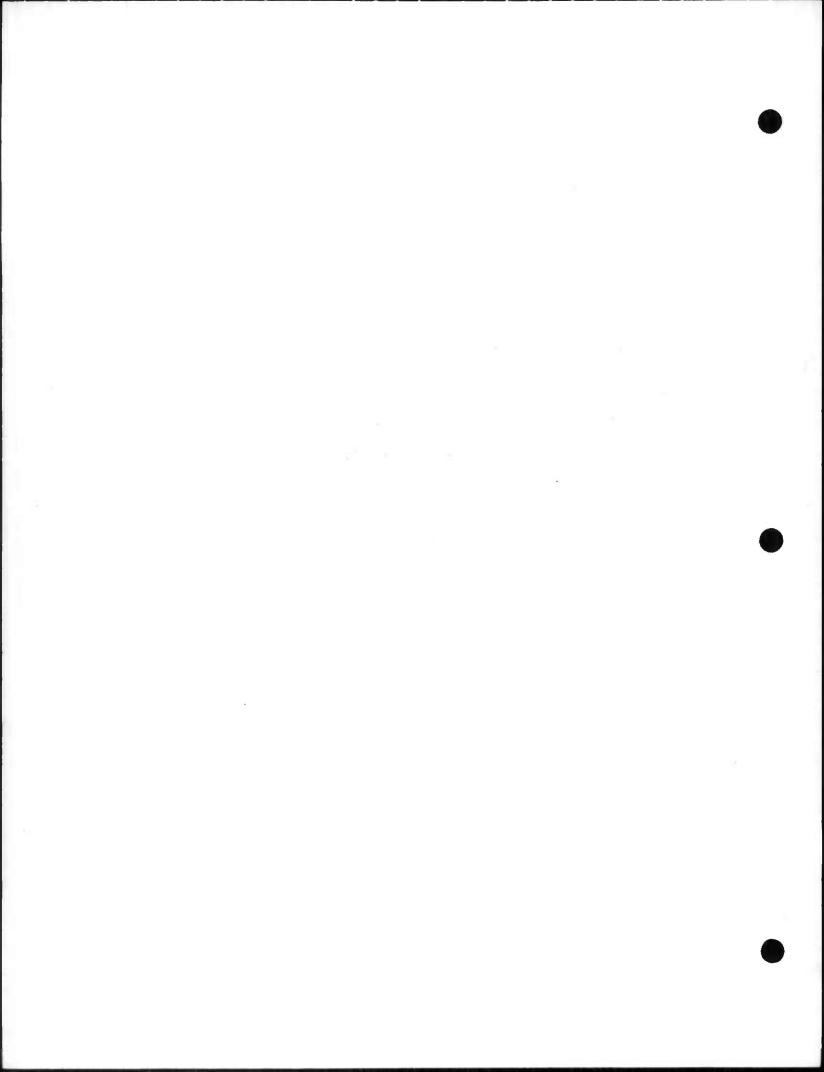
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: Activities that been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF I | | MENTA | L HYGIEN | E | | | | |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------|-------------------------|----------------------|------------|-----------------------|----------------|----------------|------------------------|---------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) |) | | | | | E OF DEATH | | 3. 1 | TIME OF OEA | TH | |
| | Albert Ralph | n Williams | | | | SEI | THEMPERO! | 6 19 | 95 I | 1. 28 | a, M | |
| 3 | 4. SOCIAL SECURITY NUMBER | | In yrs. lest birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | BIRTHPLA | CE (State or F | - | |
| | 220-10-4294 | 1 🔀 M 2 🗌 F | 74 YRS. | MONTHS DAYS | HOURS MIN. | . 4, 19 | 20 | Country) PENNS | YLVAN | IA | | |
| _ [| 9a. FACILITY NAME (If not institution, give | | | | OR LOCATION OF D | EATH | | | Y OF DEATH | 1 | | |
| PO I | | rial Hospit | al | Balt | | NA | | | | | | |
| 딥 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | TY | 10c CITY | . TOWN OR LOCA | MON | | 10d, INSIDE CITY | | | | | |
| 뜽 | MARYLAND | | | | | | LIMITS? | | | | | |
| 7 | 10e. STREET AND NUMBER | | B | BALTIMORE 109, ZIP CODE | | | | | | YES 2 | NO | |
| ER/ | 3042 Abell Ave | 0 | | | 21218 | | | | USA | | | |
| FUNERAL DIRECTOR | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGI | N? (Specify Yes | | | American Indi | an. | |
| | 1 Never Married 2 X Married | FORCES? 1 TYES | 2 NO | | Rican, etc.) | | Black, Wh Specify: | ilta, etc. | | | | |
| ВУ | 3 Widowed 4 Divorced | WW II | | | 2 NO Spech | | | | WHIT | E. | | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad | UCATION (e completed) | 16a. DECEDENT'S I | ork done during me | ON asl of working | 161 | b. KIND OF BUS | INESS/INDUS | TRY | | | |
| ۳ | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | - | | | | | | | |
| ME | 17, FATHER'S NAME (First, Middle, Last) | NIA | Tru | ck Driv | | | | uto P | arts | | | |
| | , ., | | | | 16. MOTHER'S NA | | | , | | | | |
| BE | Harry Sant | ord Williams | 105 11411 1110 | 1000500 101 | Jennie I | | | | | Cread | У | |
| 2 | | | | | | | | | ode) | | | |
| | Jean M. Willi: | | PLACE AND DATEO | | L Ave., | BAILC | | ZIZIS | | 20.4 | | |
| | ty Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify) | noval from Stata cem | etery, cremetory or other ardens of | her place! | inie oi | Sej | | ilto., | | Matte | | |
| | 21. SIGNATURG OF FUNERAL SERVICE L | ICENSEE 7 1017 | aruens o | | D ADDRESS OF FA | | DE Da | 11000 | FID | | | |
| | Daga | well the | ry | | non Fune: | | | | _ | | ,Inc. | |
| \dashv | 23. PART I. Enter the diseases, or | complications that could | the death Death | 10 1 | V. Padon | ia Ro | d., Tim | onium | , MD | | | |
| | shock, or heart fellure. | List only one cause on et | ich ine. | ot enter the mo | ae or ayıng, suc | n aa can | diec or reapi | atory arrea | t. | Approxim interval B | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Septic Shock. Due to (or as a consequence of): | | | | | | | | | | | |
| ı | resulting in death) | a. SEPTIC | STIOUR | | | | | | | $\perp d$ | ay | |
| _ | Neuhannia | | | | | | | | | | 0 | |
| <u>0</u> | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | | | | | | | | _ 20 | ayp | |
| CERTIFICATION | cause. Enter UNDERLYING | | itic lumphoma. | | | | | 2 4/10) | | | | |
| Ë | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events C. Metastatic Lymphoma. DUE TO (OR AS A CONSEQUENCE of): | | | | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | | |
| | PART II. Other aignificent condition | ns contributing to deeth br | ut not resulting in | the underivin | ceuse olven in | Part i | 24a. WAS AN | MITTOREY | 245 WEB | E AUTOPSY FI | INDINO. | |
| CAL | | | | | g -outo given in | | PERFOR | WED? | AWAJ | LABLE PRIOR | TO | |
| | | | | | | _ | 1 TYES 2 | K NO | OF E | DEATH? | | |
| ≥ | DID TOBACCO USE CONT | PIRLITE TO CALISE O | E DEATH VE | S D NO E | UNCERTAI | N Def | | | 1 - | YES 2 | NO | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH | | DIACEKIAII | A IS | | | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Output | | OTHER: | e 5 🗆 Residence | 0 0 04 | (0 | | | | | |
| Ħ | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | OF 28c. INJ | | | SCRIBE HOW IN | JURY OCCUR | RED | | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJU | M 1 . | RK? 'ES 2 NO | | | | | | - 1 | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | — At home, farm, st | reet, factory, offic | | 281. LOC | ATION (Street at | nd Number or | Rural Route | Number, | | |
| Ĕ | 4 Homicide determined | building, atc. (Speci | пу) | | | City | or Town, State) | | | | - 1 | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYS | BICIAN: To the best of my knowle | edge, death occurred | at the time date | and place, and due | to the on | | | | | | |
| N N | one) 2 MEDICAL EXAMINI | ER: On the basis of exemination | and/or investigation | , in my opinion, d | eath occured at the | time, data | and place, and | due to the c | euse(a) and | menner as a | tated. | |
| S I | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NUI | | 1 | | | th, Day, Year) | | |
| m | AL | Sect 11 | D | į | POSOU | 9 | | ▶ 9 | 1 C 1 | ac real | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WE | O COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, I | Print) | 10007 | | | ı | 101 | 13 | | |
| | ASAD, FAR | ZHANA | Union | Memo | dal LL | mi | 100 | Bull | Baltimore, md. | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | TURE | | 111 12 | 27/1 | 1111 | 1 | TILL | 7 | 11/31 | |
| | SEP 0 81995 | Jahri Mudsonka | well | | | | | | | | | |





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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | L HYGIENE |
|--------------|-----------------------------------------------------|-----------|
| REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |

| 1 - STATE REGISTRAR | SIRIE UF I | MANTLA | CERTIF | ICATE | OF | | | MENTA | REG. NO | | | | | |
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| 1. DECEDENT'S NAME (First, Middle, Last) | ISER | | | | | | | 2. DATE MORT | TEN DE | AY 4. 1 | YEAR | 3. TIME OF DEATH 0224 A M | | |
| 4. SOCIAL SECURITY NUMBER | 5. 9EX | 6. AGE (In | yrs. lest birthday) | IF UNDER 1 | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | OF BIRTH | s, BIRT | | PLACE (State or Foreign | | |
| 076-26-3789 | 1 - M 2 X F | | 7 YRS. | MONTHS | DAYS | HOURS | MIN. | | (i, Day, War) | 000 | Novi | | | |
| Se. FACILITY NAME (If not institution, give | street end number) |] 2 | 97 YRS. May 21,1 | | | | | | | INTY OF D | | | | |
| | | | | Po | tha | -4- | | | | Mo | ntao | morii | | |
| Suburban Hosp: | LLal | | | Bethesda Montgome | | | | | | шету | | | | |
| Suburban Hosp: RESIDENCE OF DECEDENT 100. STATE 100. COUNT Maryland Mon: | ry | | 10c. CI1 | Y, TOWN O | R LOCATI | ON | | | | | | 10d. INSIDE CITY LIMITS? | | |
| | tgomery | | Ro | ckvi. | | | | | | 1 ☐ YES 2 🎇 NO | | | | |
| 10e. STREET AND NUMBER | | | | | | ZIP CODI | | | | " | 0g. CITIZEN OF WHAT COUNTRY? | | | |
| 10. STREET AND NUMBER 6121 Montrose 11. Marital Status 1 Never Married 2 Merried | | | 17.70 | | | 0852 | | | | | .S.A | | | |
| 11. MARITAL STATUS | 12. WAS DECEDED FORCES? | 1 YES | 2 NO | H | yes, spe | city Cube | n, Mexica | in, Puerto | N? (Specify Ye Rican, atc.) | s or No | Black | E — Americen Indien, k, White, etc. | | |
| 3 X Widowed 4 Divorced | IF YES, GIVE WAR O | | | | | 2 A NO | Specif | À. | | | Whi | | | |
| | | 1 | 60. DECEDENT'S | USUAL OC | CUPATIO | N | | 168 | . KIND OF BU | SINESS/IN | | LE | | |
| (Specify only highest grad | College (1-4 or 5 | +) | (Give kind of life. Do NOT L | work done d ise retired.) | furing mos | t of working | ng | | | | | | | |
| 10 | | | Homem | aker | | | | | Own | home | е | | | |
| 15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12) 10 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOT | HER'B NA | AME (First, | Middle, Meiden | Surname) | | | | |
| Abraham Pashi | nsky | | | | | Mo | 0113 | y Ab | rams | | | | | |
| 19e. INFORMANT'S NAME (Type/Print) | | | 19b. MAILIN | ADDRESS | (Street or | nd Number | r or Rural | Route Num | ber, City or Tov | vn, State, Z | ip Code) | 20902 | | |
| Mervin weiser | | | 1170 | 3 Ke | mp | Mil: | l Ro | d., | - | | | | | |
| | 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of page 1) Cremetton 3 Removal from State camples of complete camples of the place of page 1) Cremetton 3 Removal from State camples of the place of page 1) Removal from State camples of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the | | | | | | | | | | | | | |
| 4 Donation 5 Other (Specify) | | | | | | | | | | | | | | |
| 21. SIONATURE OF FUNERAL BERVICE L | Ives-Pearson Funeral Homes | | | | | | | | | | | | | |
| Cont. Hollan | Falls Church, Va 22046 | | | | | | | | | | | | | |
| 23. PART i. Enter the diseases, or ahock, or heart fellure | complications th | at caused t | the deeth. Do | not enter | the mo | de of dy | ing, suc | ch aa car | diac or reap | eiretory a | rreat, | Approximata Interval Between | | |
| IMMEDIATE CAUSE (Finel | Onset and Death | | | | | | | | | | | | | |
| disease or condition resulting in death) a. (on OFITY & HOART PAILURE 2 day) | | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| if any, leeding to immediate cause. Enter UNDERLYING | if any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| CAUSE (Disease or injury | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | that initieted events | | | | | | | | | | | | | |
| | | | | | | | | | 1 | | | | | |
| PART II. Other eignificent condition Ryn AL | | | | in the un | derlying | cause | given in | Part i. | | RMEG? | 248 | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | 7 77 70 | | | | | | | | 1 TYES | 2 NO | | OF DEATH? | | |
| | TDIDLITE TO 6 | ALISE OF | DEATH M | C \ | 10 [| 1.15.14 | TEDTAL | | | | | 1 YES 2 NO | | |
| DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | TRIBUTE TO CA | | B. PLACE OF DE | | | UNC | ERTAI | ΝЦ | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | R: | | | | | | | | | |
| 1 U YES 2 NO | 1 Inpatient 2 | - | tient 3 ∐ DOA | | 26c, INJ | _ | aeldenca | | er (Specify) | IN ILIBA O | CCURED | | | |
| | (Month, | Day, Year) | | JURY | WO | RK? | NO. | 200.00 | GOMOL HOW | | OOUNED | | | |
| 2 Accident Investigation 3 Suicide & Could not be | 26e. PLACE | OF INJURY - | - At home, farm | atreet, fact | | | | 28f. LO | CATION (Street | and Numb | er or Rural | Route Number, | | |
| U 4 Homicide datermined | building | g, atc. (Specify | y) | | | | | City | or Town, Stete |) | | | | |
| 290. CERTIFIER | COLOURNI, To the head | at any bananta | | | | 4 -1 | | | | | | | | |
| (Check only | | | | | | | | | | | | e) end menner ee atsted. | | |
| 3 | | | | ,, | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIF | rollen | 0 | 2 | | | Z9c. LIC | ENSE NU | MBER | 218 | 29d. 0/ | FO T | OLL. 1995 | | |
| 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CA | USE OF OFAT |) TH (ITEM 27) /3~ | ne Print) | | | | 1 | ٠,٠٥ | 2 | - 1 ' | - TI 11- | | |
| Gu CITAISU | m1, 1 | 1119 | Rocte | VIII | E | PIL | e-, | RI | reter | W | 1 | 04, 1995 | | |
| SED 0 8 1995 | 2. ATGISTI | S SIPHY | TURE | | | | | | | | | | | |

NOT THE

1 - FOR STATE

ITEM: 23 PART I, PER DR. FILM G-727 9/8/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| _ | REGISTRAR | | | | OLITIII | OAIL | JI DEA | | ne. | G. NO. | | | | |
|------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------|----------------------|-----------------------------------------------------------------------------------------------|----------------------------|------------|-------------------------------|----------------------------------|-----------------|-----------------------|--------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Edith | | llace | | | | | | 2. DATE OF DI MONTH | EATH DAY | | RA | ME OF DEATH | |
| 1 | | | | | . ==, | | | | Septem | | 1, 1995 Y; OOPM | | | |
| | 4. SOCIAL SECURITY NUMB 214-40-08/4 | ER | 5. SEX | | s. last birthday) | MONTHS D | AR IF UNDE | PI 24 HRS. | 7. DATE OF BI (Month, Day, | Year) | (| Country) | CE (State or Foreign | |
| | 214 - 40 - 007 | | 1 🗌 M 2 🗓 📉 | 5 | 6 YRS. | | | | | | | | MD | |
| | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY O | | | | | | | | |
| | 2503 Sycam | ore A | Ave. | | | Edgemere | | | | | Baltimore | | | |
| 2 | 10a. STATE | 10b. COUNTY | · | | 10c. CIT | Y, TOWN OR L | OCATION | | | _ | | 10d | INSIDE CITY | |
| 5 | MD | Ba | altimore | 2 | | Edge | mere | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | | | | | | 10f. ZIP COI | DE | | 10 | g. CITIZEN | OF WHAT | COUNTRY? | |
| EDAL | 2503 Sy | camoi | ce Ave. | | | 21219 | | | | | | USA | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER II | | | | | 13. WAS | DECENDENT | OF HISPAI | NIC ORIGIN? (Sp | ecify Yea or I | No- 14. | RACE - / Block, Wh | merican Indian, | |
| | 1 Never Married 2 📉 | | FORCES? 1 IF YES, GIVE V | | | | s, specify Cub YES ②∰NO | | in, Puerto Rican, y: | etc.) | | Spacific | | |
| 0 | 3 Widowed 4 Divo | rced | | | | | | | | | | | Black | |
| ED I | 15. DEC (Specify only | EDENT'S EDU higheal grade | CATION completed) | 184 | Give kind of | work done duri | PATION og most of work | ing | 16b. KIND | OF BUSINE | SS/INDUS | TRY | 2 | |
| 4 | Elementary/Secondary (0 | -12) | College (1-4 or 5 | +) | ille. Do NOT u | | | | | Dog | | | | |
| COMPL | 12th | | | | Co | OK | | | | Restaurant ddle, Meiden Sumeme) | | | | |
| - 1 | unk. | iddle, Last) | | | | | | | ie Ful | | | | | |
| L D | 19a, INFORMANT'S NAME (| | | | | | | | Route Number, Ci | | | ela l | | |
| 2 | Kenneth A | | 11200 | | | | | | e. Bal | | | | 10 | |
| | | | LIACE | 20h BI | ACE AND DATE | _ | | - AV | | 20c. LOCATI | | | | |
| | | 1 ∯ Porlat 2 □ Cremetion 3 □ Removal from State | | | | | NA Norma Or | | 9/6 | | | | | |
| | 21. FIGNATURE OF FUNERA | | 330996 | <u> </u> | 11y H | ills 9/6 Baltimore, MD 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home | | | | | | | | |
| | 6/00 | * Comes (M | | | | | | | | | | | | |
| _ | yame | 1701 Laurens St. Balto., MD 21217 3. PART Lighter the diseases, or complications the caused the deeth. Do not enter the mode of dying, such se cerdice or respiratory arrest, Approximate | | | | | | | | | | | | |
| | 23. PART Intenter the d shock, or h | eert failure. | List only one cal | seumed th | e deeth. Do lina. | not entar th | moda ot d | ying, suc | ch ee cerdiec (| or respirato | ory arrest | 1 | Interval Between | |
| | Memoriale cause (min) | | | | | | | | | | | Onset end Deeth | | |
| | disease or condition resulting in death) out to (or as a consequence of): | | | | | | | | | | | SWIN. | | |
| | | | 002 10 | OR AS A CO | MSECUENCE C | rj: | | | | | | | | |
| 5 | Sequentially list condit | | b. DUE TO | (OR AS A CO | NSEQUENCE C | F): | | | | | | | | |
| ALION | If any, leading to imme cause. Enter UNDERLY | ING | | | | | | | | | | | | |
| HIFF | CAUSE (Disease or Injuited that initiated events | iry | DUE TO | (OR AS A CO | NSEQUENCE C | F): | | _ | | | | | | |
| 2 | resulting in daeth) LAS | resulting in daeth) LAST | | | | | | | | | | | | |
| 2 | PART II. Other algnifice | nt condition | na contributing to | death but i | not resulting | in the unde | riving cause | given in | Part I. 24a. | WAS AN AUT | TOPSY | 24b. WE | RE AUTOPSY FINDINGS | |
| 3 | - | | | | | | | | | PERFORME | 0? | AWA | ILABLE PRIDR TO MPLETION OF CAUSE | |
| | | | | | | | | | 10 | YES 2 (V | NO | | DEATH? | |
| Σ | DID TOBACCO U | ISE CONIT | DIRLITE TO CA | LISE OF I | SEATH V | ES NO | M IIN | CERTAI | N D | | | 1 1 | YES 2 NO | |
| AN | 25. WAS CASE REFERRED T | | T TO CA | | PLACE OF DEA | | | CLKIAI | | | | | | |
| 2 | EXAMINER? | | HOSPITAL: | ED/Outpetle | mt 2 🗆 004 | OTHER: | 17 | ļ | 8 Other (Spi | -46.1 | | | | |
| PHTSICIAN: | 27. MANNER OF OEATN | | 28e. DATE OF | F INJURY | 28b. TII | AE OF 28 | c. INJURY AT | RESIDENCE | 28d. DESCRIB | | JRY OCCUP | RED | | |
| | | Pending | (Month, I | Day, Year) | IN | JURY | WORK? | □ NO | | | | | | |
| 0 | 2 Accident 3 Suicide | Investigation Could not be | 28e. PLACE | OF INJURY - | At home, farm, | street, factory | office | | 281. LOCATION | | Number or | Rural Route | Number, | |
| 1 | 4 Nomicide | determined | building | , etc. (Specify) | | | | | City or Tox | wn, State) | | | | |
| 4 | 29a. CERTIFIER 1 CER | TIFYING PNYS | ICIAN: To the best o | f my knowledd | e. death occur | red at the time | data and pie | ca. and du | a to the cause(a) | and manner | r an stated. | | | |
| COMPLEIED | one) | | ER: On the besis of a | | | | | | | | | ause(a) an | d menner as stated. | |
| | 29b. SIGNATURE AND TITLE | OF CERTIFIE | SR SR | | | | 29c. L | CENSE NU | MBER | 21 | 9d. DATE S | IONED (Ma | nth, Day, Year) | |
| מ | Dans | M | | House | STAF | F | | 941 | 016 | | 0 | 10/01 | 95 | |
| 2 | 30. NAME AND ADDRESS O | F PERSON W | | | | | | | 10 | | - | 13/ | 13 | |
| | TIM M. L | NAY, | MD J | DHNS | HOPK | INS B | AYVE | Eda J | MED (| TR | RA | LTIM | ORE MD | |
| | 31. DATE FILEO (Month, Day, | Year) | | AR'S SIGNATU | | 11000 | / / / | 700 | | (| 1 | J. ([). | | |
| | SED 0 | 8 1995 | Value all | AR'S SIGNATU | ardall | | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or New 3 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

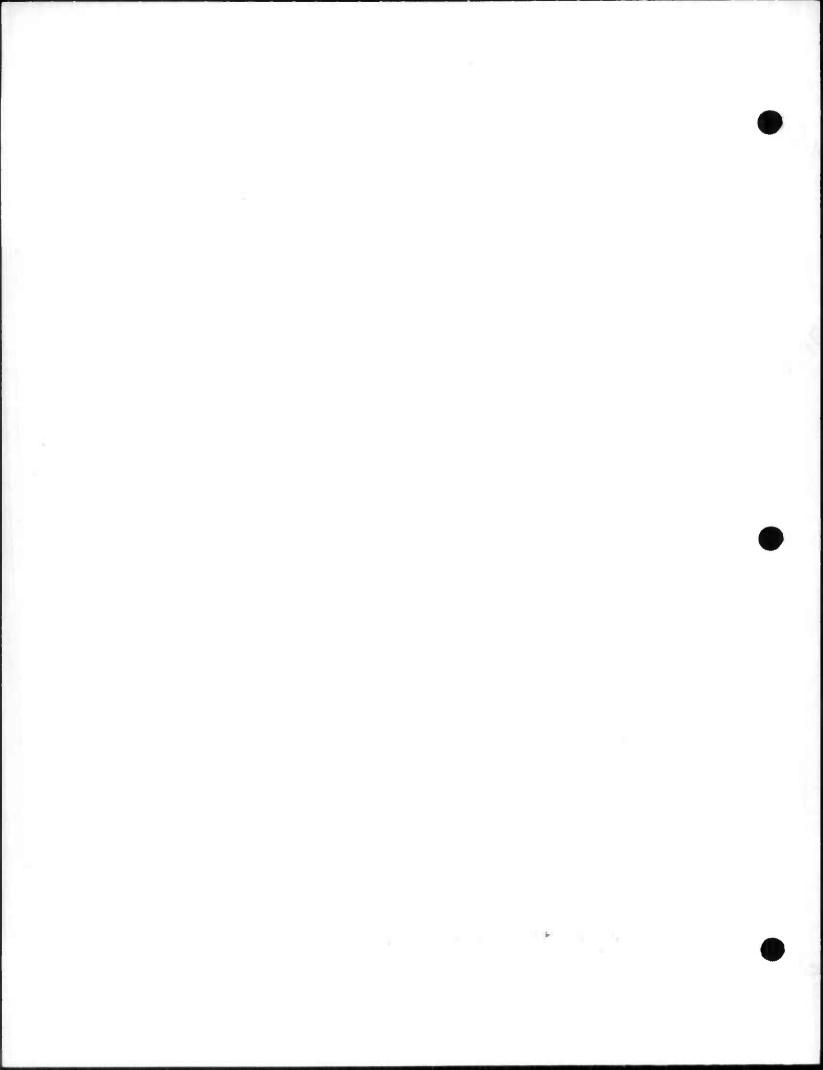
IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| FOR | | | | | THENT OF I | e di zu l | LAID I | AENTAL LIVOLENI | | | |
|-------------------------------------------------------|-----------------------|-------------------------------|--------------------------------|----------------|-------------------------------|----------------|-----------|----------------------------------------------------|------------|-------------------|------------------------------------------------|
| 1 - STATE REGISTRAR | 2 | SIAIE UF N | | | IMENI UF F | | | WENTAL HYGIENE REG. NO. | - | | |
| 1. DECEDENT'S NAME (First, M | liddle, Last) | | | | | | | 2. DATE OF DEATH | , | YEAR | 3. TIME OF DEATH |
| Melvin Herald | Widerma | an | | | | | | | , 199 | | 9;00 A. ™ |
| 4. SOCIAL SECURITY NUMBER | | SEX | a. AGE (In yrs. | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 2 | 4 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | a. BIRTH Count | IPLACE (State or Foreign ry) |
| 212-03-3266 | | X M 2 🗆 F | 87 | YRS. | | | | December 5.1 | | | ryland |
| se. FACILITY NAME (If not instituted as 1301 Wildwood | Beach Ro | | | | 9b. CITY, TOWN | OR LOCATION | N OF DE | ATH | | ltimo | |
| RESIDENCE OF DECE | DENT | ,aa | | | | | | | | I CINC | |
| | Dolt: | | | | Y, TOWN OR LOCA | TION | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland | Baltimo | ore | | Esse | | I. ZIP CODE | | | 10a, CIT | IZEN OF | 1 YES 2 NO WHAT COUNTRY? |
| 1301 Wildwood | Roach Roa | he | | | | 21221 | | | | U.S.A | |
| 11. MARITAL STATUS | 12. | WAS DECEDEN | T EVER IN U.S. | | | ENDENT OF | | IIC ORIGIN? (Specify Yee n, Puerto Rican, etc.) | | 14. RAC | E — Americen Indien, k, White, etc. |
| 1 Never Married 2 M 3 X Widowed 4 Divorce | | IF YES, GIVE W | | UNO | | 2 X NO | | | | Spec | alty: |
| 15. DECEC | DENT'S EDUCATION | | 16a. | DECEDENT'S | USUAL OCCUPATI | DN | | 16b. KIND OF BUS | INESS/INI | DUSTRY | White |
| (Specify only h | nighest grade comp | pleted) ollege (1-4 or 5 - | | ife. Do NOT us | | ost of working | 1 | | | | |
| | | 4 | | C.E. | 0. | | | Commercial | & Fa | rmers | Bank |
| 17. FATHER'S NAME (First, Midd | | | | | | - | | ME (First, Middle, Malden S | Surname) | | |
| Harry L. | Widerman | | 1 | 105 MAII IMC | ADDRESS (Street | | | e W. Bond Route Number, City or Town | Otata 76 | n Codel | |
| Mrs. Joyce R. M | | | | | Cavendish | | | | | 059 | |
| 20a. METHOD OF DISPOSITIO | N | | | E AND DATE | OF DISPOSITION (N | | 110 | | | | own, State |
| 1 Suriel 2 Cremation 4 Donetion 5 Other (S | | from State | Parky | vood Ce | metery | | 9/6/ | | more | , Mar | ryland |
| 21. SIGNATURE OF FUNERAL | SERVICE LICENT | 7/ | | | | NO ADDRES | | Funeral Home | Inc | | |
| "World (| Sel | ser , | L. | | | | | d- Baltimore. | | | 21214 |
| 23. PART I. Enter the disc | eeaea, or com | pfications the | t caused the | deeth. Do i | not enter the me | de of dyln | ig, suc | h as cerdiac or respi | ratory ar | reat, | Approximeta Interval Between |
| IMMEDIATE CAUSE (Fina | | On. | | . 1 | 11 | -1 | | | | | Onset and Death |
| disease or condition resulting in death) | # | 11) no | coud | in la | lafer | Z Lu | ×_ | | | | |
| | | 0097 | (OR AS A CONS | зеаиенсе о | 1 1 | S | | | | | 150 |
| Sequentially list condition | | DUE TO | IOR AS A CONS | EQUENCE O | جيناليانيو ر | 1 | | | | | 13/4 |
| if any, leeding to immedicause. Entar UNDERLYIN | G D | Hered | theral | Na | seule | i d | | 11 | | | 2 mgs. |
| CAUSE (Disease or injury that initiated events | | DUE YO | (OR AS A CONS | EQUENCE O | F): | | | | | | |
| resulting in deeth) LAST | 6.1 | coro | non | art | is de | rea | - | | | | 10 yrs. |
| PART il. Other algnifican | t conditions co | ontributing to | deeth but no | t resulting | in the underlyin | g cause g | ivan in | Part i. 24a. WAS AN PERFOR | | 24 | b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| | | | | | | | | 1 TYES 2 | | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | -1 | , | | 1 TES 2 NO |
| DID TOBACCO US | | UTE TO CA | | | | | ERTAI | NZ | | | |
| 25. WAS CASE REFERRED TO EXAMINER? | H | OSPITAL: | | | TH (Check only one, OTHER: | | 25 | | | | |
| 1 TYES 2 THO | 11 | 28e. DATE OF | ER/Outpatient | 28b. TIA | | JURY AT | sidence | 8 Other (Specify) 28d. DESCRIBE HOW II | NJURY OC | CURED | |
| 1-Metural 5 P | ending restigation | (Month, L | | IN | | ORK? | NO | | | | |
| 2 Cultida | ould not be | 28e. PLACE (| OF INJURY — At, etc. (Specify) | home, larm, | streel, lectory, offi | ce | | 28I. LOCATION (Street e City or Town, State) | nd Numbe | r or Rural | Route Number, |
| 4 Homicide de | etermined | outlasting. | , etc. (capcony) | | | | | Only or rown, oraco, | | | 2.00 |
| 29e. CERTIFIER (Check only | FYING PHYSICIAI | N: To the best o | f my knowledge, | death occur | red at the time, dat | e end place, | end du | lo the cause(a) end man | ner ee ste | nted. | |
| one) 2 MEDIC | AL EXAMINER: 0 | on the beele of e | examination and/ | or investigati | on, in my opinion, | death occure | ed at the | ilme, date end piece, en | d due to 1 | the couse | s) end manner as stated. |
| 29b. SIGNATURE AND TITLE | CERTIFIER | 11 B | 1 . | , | | 29c. LICE | NSE NU | MBER | 29d. DA | TE SIGNE | D (Month, Day, Year) |
| 20 NAME AND ADDRESS OF | DESCON WILL | 1/ nel | 2/2 | TEM OF C | Orlean | 10 | 4/ | 600 | | 7/5 | 145 |
| 30. NAME AND ADDRESS OF | | / | | | | Maxwla | nd | 21221 | | | |
| Adolph Wychuli 31. DATE FILED (Month, Day, Ye | | 32. REGISTR | stern Ave | E | <u>ltimore</u> , | ındı yıd | ııu | <u> </u> | | | |
| SEP 081 | 1995 8 | alia de | elsor-Ran | 64 | | | | | 11 | | |

FOR STATE

| | | | REGISTRAR | 1 | CER | ITIFICATE | OF DEATH | REG. NO | | | | |
|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------|------------------|------------------------|---------------------------------|--|
| 4 | | | DECEDENT'S NAME (First, Middle, Last) Duit | TTD LITETA | 110 | | | 2. DATE OF DEATH | AV VE | EAR | AE OF DEATH | |
| | | | | LLIP WILLIA | | | | AUG. 26 19 | 195 | 2: | 50PM w | |
| | | | 4. SOCIAL SECURITY NUMBER | | VGE (In yrs. lest bir | | | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTHPLACE Country) | (State or Foreign | |
| | D | | 223-60-7296 | 1 M 2 D F | 91 | YRS. | DAYS HOURS MIN. | APRIL 15 19 | | VIRGIN | IA | |
| | should | | 9e. FACILITY NAME (If not institution, give s | treet end number) | | 9b. CITY, | TOWN OR LOCATION OF D | | 9c. COUNTY | | | |
| | 2, 3 | 뜅 | ANNE ARUNDEL MEDI | CAL CENTEE | R | ANI | NAPOLIS | | ANNE | E ARUN | DEL. | |
| | ₩. | DIRECTOR | RESIDENCE OF DECEDENT | | | 11111 | THE OBJECT | | | J MKON | DEL | |
| | permit. Pages | 2 | 10e. STATE 10b. COUNTY | 1 | 10 | Oc. CITY, TOWN OF | LOCATION | | | 10d. IF | NSIDE CITY | |
| | 4 | ā | VIRGINIA | | | HAPPY | CREEK | | | | YES 2 NO | |
| | Deci | AL | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | OF WHAT CO | OUNTRY? | | |
| | -TS | FUNERAL | ROUTE 3 | | | | 22630 | | SA | | | |
| cian | bunial-transit | 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | ER IN U.S. ARMED |) 13, W | AS DECENDENT OF HISPA | NIC ORIGIN? (Specify Yes | | . RACE — Am | ericen Indian | |
| 020 Phys | Duni | | 1 K Never Merried 2 Merried | FORCES? 1 Y | R DATES X | и | yes, specify Cuben, Mexic YES 2 X NO Speci | en, Puerto Rican, etc.) | | Black, White. | | |
| O-guilo | 2 | В | 3 Widowed 4 Divorced | | n on Lo | '' | □ FES Z DA NO Speci | ry: | | Specify: BL | ACK | |
| 215-0020 attending physic | use as | 8 | 15. DECEDENT'S EDUC | | 16a. DECED | ENT'S USUAL OC | CUPATION | 16b. KIND OF BUS | SINESS/INOUS1 | TRY | | |
| 213 | for us | COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 pr 5+) | life. Do | NOT use retired.) | iring most of working | | | | | |
| Spita | pa . | | 0 | 0 | FΔ | RMER | | SELF EN | ADI OVET |) | | |
| Z 2 | detached once. | ON | 17. FATHER'S NAME (First, Middle, Lest) | | | THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE T | 10. MOTHER'S NA | AME (First, Middle, Meiden | | | | |
| RYLAND ed by the hospit | a te | | IINKNOW | 733 | | | | | | | | |
| Pe Pe | ponid Fed | BE | 190. INFORMANT'S NAME (Type/Print) | LIN | 10h M | All ING ADORESS | (Street end Number or Rural | NOWN | - On the Time On | | | |
| MA | 5 should notified | 2 | | | | | | | | 30) | | |
| m, y | D age | | MELVIN REYNOLDS 20a. METHOD OF DISPOSITION | | | | LANE ANNAP | | | | | |
| O.B. | must | | 1 N Burial 2 □ Cremetion 3 □ Reme | | | PE CEME | | | CATION — City | | | |
| M | direc | - 1 | 4 Donation 5 Other (Specify) | | GOOD HO | | | | NT ROYA | AL, VI | RGINIA | |
| ALTIMORE, death. Page 6 may b | e funeral dir il. examiner | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | 22. N. RET | AME AND ADDRESS OF FA | MORTHARY. I | P.A. | | | |
| BAL er dear | the funeral director, page wal. | l å | Lavy M. Ke | ese | | | | | | 401 | | |
| E P | d in by the or remova medical | | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one earns on each line. Approximate interval Retween | | | | | | | | | |
| BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physician. | filled in on, or re | | shock, or neart renure. | List only one oruse o | n each lina. | 710 | , , , , , | | idiory arrest, | 10 | nterval Between | |
| F | ₩ 6 W | - 1 | IMMEDIATE CAUSE (Fine) | SF | -1/C | 7/5 | | | | 10 | Onset and Death | |
| 0 | completely fille ial, cremation, event, the | 1 | resulting in death) | DUE 10-10RV | NE A COMPECUE | HOE ORD A C | 1000 | | | | | |
| 68760 executed with | 8 - 8 | _1 | | | KIE | UN | (C) W 17 | 1 | | | | |
| 39 | ing physician and congiene prior to burial, other traumatic e | CERTIFICATION | Sequantially list conditions, | bDUE TO (OB4) | AS A CONSEQUE | CONTRACTOR OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE | | 21 | | | | |
| O B | the attending physician Mental Hygiene prior to Ijury, or other traur | A | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| S, P.O. BC | phys ne pi | 윤 | CAUSE (Disease or Injury that initiated events DUE TO (OTTAS A CONSEQUENCE OF): | | | | | | | | | |
| 0 8 | nding ph Hygiene or other | E | that initiated eventa resulting in death) LAST | | | | | | | | | |
| O the | he attendi Mental Hy Jury, or | 8 | | 1 | NE | | 1010 | | | | | |
| 0 4 | y the ath of Menta injury, | | PART II. Other algorificant condition | s contributing to deat | th but not rasu | iting in the und | arlying cause given in | Part I. 24a, WAS AN | | 24b. WERE / | AUTOPSY FINDINGS | |
| OR | D 5 - | EDICAL | 100 | mdo - | | | | PERFOR | | | BLE PRIOR TO LETION OF CAUSE | |
| U & | Health a | | 1000 | JULY | | | | 1 _ YES 2 | X NO | OF DEA | ATH? | |
| RE | 3 0 e | Σ | DID TORACCO LISE CONTE | DIDLITE TO CALICE | OF DEATH | VEC 🗆 N | O D INICEPTAL | | | 1 🗆 Y | ES 2 NO | |
| AL law | 23 | A | DID TOBACCO USE CONTE | GBOTE TO CAUSE | | F DEATH (Check on | | иП | | | | |
| F 5 | State | SICI | EXAMINER? | HOSPITAL: | | OTHER: | | | | | | |
| F V | certificate the State , or item | ĭ. | 1 YES 2 NO | 1 Inputiont 2 FR/C | | | ng Home 5 - Residence | 6 Other (Specify) | | | | |
| PHYSICIAN: | with with | РНҮ | 1 Natural 5 Pending | (Month, Day, Yea | RY 26 | b. TIME OF 2 | 8c. INJURY AT WORK? | 28d. DEŞCRIBE HOW II | NJURY OCCURE | ED | | |
| NG N | | E I | 2 Accident Investigation | | | M | 1 YES 2 NO | | | | | |
| DIVISION OR ATTENDING F | A 0 88 | 8 | 3 Suicide 8 Court not be | 28e. PLACE OF INJI building, etc. (5 | URY — Al home, Specify) | ferm, street, tector | y, affice | 28f. LOCATION (Street e City or Town, Stete) | and Number or R | Turel Floute Nu | imber, | |
| N FA | rs afte | E. | | | | | | | | | | |
| D 807 | | MPL | 290. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my ki | nowledge, death (| occurred at the tim | e, date end place, and due | to the cause(e) end men | mer es stated. | | | |
| PITA | in 72 | § I | one) 2 MEDICAL EXAMINE | | | | | | | use(e) end m | anner as stated. | |
| THE HOSPITAL | THE FUNERAL filed within 72 PORTANT: II | 21 | 296 SIGNATURE AND TITLE OF CERTIFIER | (V | 10 | | | | | | | |
| 岩 | E B D | 8 | Rygoles | 200 1 | WIL |) | 29c. LICENSE NU | \$T10 | 29d. DATE SIG | SNED (Month. | 700 | |
| 2 | ₽ ¥ E | 2 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETES SALIS | | <u></u> | 4 | 11-0 | | 1/- | 1-67 | |
| | - | | FIAAA A PERSON WHO | O COMPLETEO CAUSE OF | 4 | , | e A./.= | | | | | |
| | | | LINIU GAYO | > 0 161 | 00 W | IKEN | s AVE. | | | | 17-1 | |
| - | | | ST. DATE FILED (MONTH Day Year) | 32. REGISTRAR'S S | GNATURE | | | | | | | |
| | L | | SED U 8/13 | 100 June | imarter M | attall | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

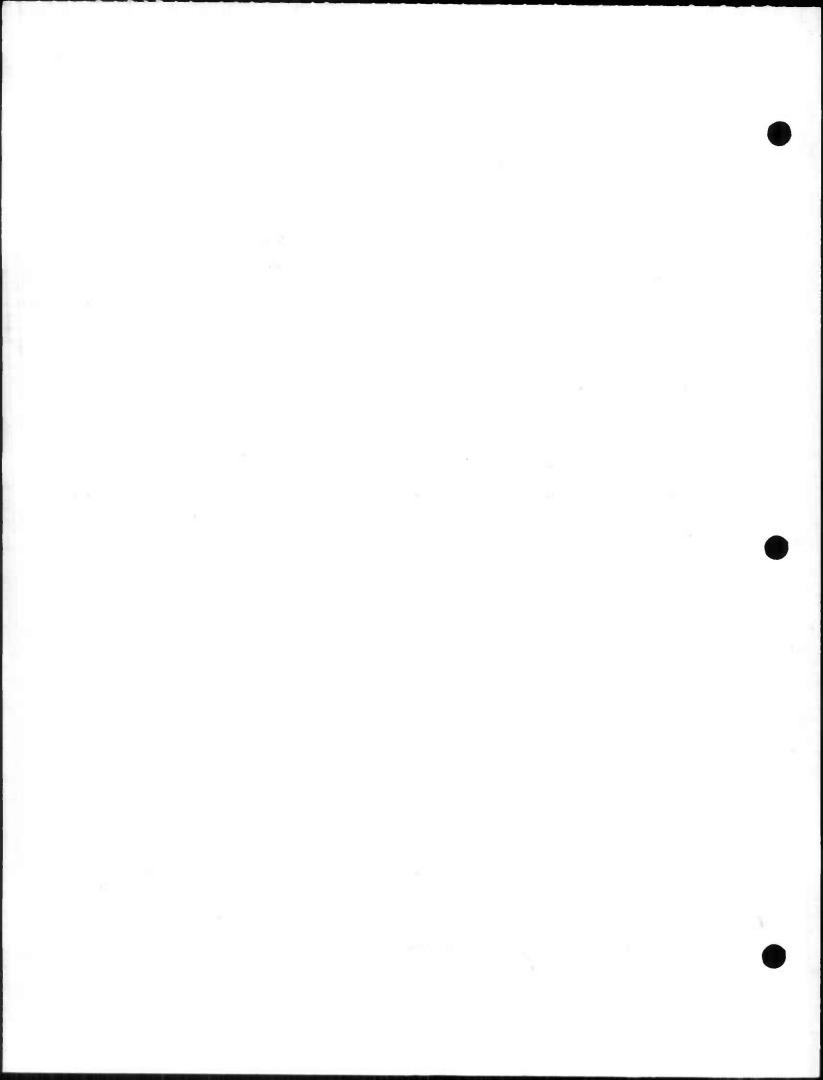
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

| _ | HEGISTRAH | | | U | ENTIF | CAIL | OFL | JEAIN | | MEG. NO. | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------|---------------|--------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH Sept. 4. 1995 9 AM M | | | | | |
| | ANNA LEE ZORN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) | | | | | | IF UNDER 1 YEAR | | | Sept. 4, 1995 | | | IPLACE (State or Foreign | |
| | | | | 65 | | | | HOURS MIN. | (Month | Day, Year) | 930 | Countr | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | | | 96. CITY, TOWN OR LOCATION OF D | | | | | | INTY OF DEATH | | |
| 20101 | 5 Taos Circle | | | | | Middle Rive | | | r | Baltimore | | | | |
| 2 | | | | | | Y, TOWN OF | R LOCATIO | IN . | | 10d. INSIDE CITY | | | | |
| HAL DIN | Maryland Baltimore | | | | Middle Rive | | | | r | | | | | |
| | 10e. STREET AND NUMBER | | | | | | 101. ZIP CODE 21.220 | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| LOINER | 5 Taos Circle 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | | | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify) | | | | be or No.— 14. RACE — American Indian, | | | |
| | 1 Never Married 2 Married FORCES? 1 YES 24 | | | | NO It yes, specify Cuberi, Mexic | | | | | | Black, White, etc. | | | |
| 0 | 3 Wildowed 4 Divorced | | | | | | Specify. | | | | | "White | | |
| O BE COMPLETED | (Specify only highest grade completed) (Give kind of | | | | | work done during most of working | | | | KIND OF BU | BUSINESS/INDUSTRY | | | |
| | Elementary/Secondary (0-12) College (1-4 or 5+) | | | | ite. Do NOT use retired.) Packer | | | | Glass Company | | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | | | | | 18. MOTHER'S NAME (First, Middle, Me | | | | | iden Surname) | | | |
| | Valentine Koerner | | | | | Florence Wastler | | | | | | | | |
| | | | | | | ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) iddlesex Road Essex, Maryland 21221 | | | | | | | | |
| | 20a. METHOD OF DISPOSIT | | | - | | | | | | | | | | |
| 20e. METHOD OF DISPOSITION 10 Burlel 2 Crimetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Property Company of the Proper | | | | | | | | | | LOCATION — City or Town, State Limore Co., Maryland | | | | |
| | 21. SIGNAPORE OF FUNERAL SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVI | | | | | | | | | | | | | |
| | 1407 Eastern Ave. Baltimore, Maryland 21221 | | | | | | | | | | | | | |
| | 23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or hasn failure. List only one cause on each line. Approximate interval Between Onset and Death | | | | | | | | | | | | | |
| 1 | disease or condition resulting in death) a. Suddlen Death | | | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): H & pertunia N Hebrasclerans 10 yrs. | | | | | | | | | | | | | |
| CEMILLICATION | Sequentially list conditions, If any, leading to immediate | | | | | |):/ | | | | | | | |
| 3 | CAUSE (Disease of Injury C. Arterial of | | | | | | course 3 | | | | | | 3 ym. | |
| | that initiated eventa DUE TO (OR AS A CONSEQUEN | | | | | | | | | 11 | | | 2 1000 | |
| L L | resulting In death) LAST | | | | | | carobe arthur | | | | 3 900) | | | |
| | PART II. Other algolitics | ent conditions | contributing to | death but not | reaulting | In the un | darlying | cause givan ir | Part I. | 24a, WAS AN | | 241 | . WERE AUTOPSY FINDINGS | |
| DICAL | | | | | | | | 1 | | | FORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| ш | | | | | | | | | | | | | 1 YES 2 NO | |
| 2 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | | | |
| HYSICIAN: | 25. WAS CASE REFERRED T | TO MEDICAL | HOSPITAL: | 26. PLA | CE OF DEA | | | _ | | | | | | |
| 2 | 1 TES 2 NO | ER/Outpetient | ont 3 DOA OTHER: | | | | e 6 ☐ Other (Specify) | | | | | | | |
| E | 27. MANNER OF DEATH | - 1 | | 28a. DATE OF INJURY (Month, Day, Year) | | IE OF JURY | | | 28d. DE | SCRIBE HOW | INJURY OCCURED | | | |
| 2 | 1 Netural 5 2 Accident | | М | | | | | | | | | | | |
| במ | | | | | | At home, tarm, atreet, factory, offica | | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLE | 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER 2 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, | | | | | | | | | | | | | |
| 20 | In Vim | | | | | | | MD 002022 > | | | | 9-4-96- | | |
| 2 | 30. NAME AND ADDRESS O | 111 | | SE OF DEATH (IT | EM 27) (Type | Print) | . 4. 01. | 26 Run | Ra | Bolt | ho | 1 2. | 1221 | |
| | 31. DATE FILED (Month, Day, | | Y RUSS | AR'S SIGNATURE | 100 | JI EM | in ch | | / | , | | | | |
| | SEPO | 81995 | Salin | Ludear | Latt | | | | | | | | | |





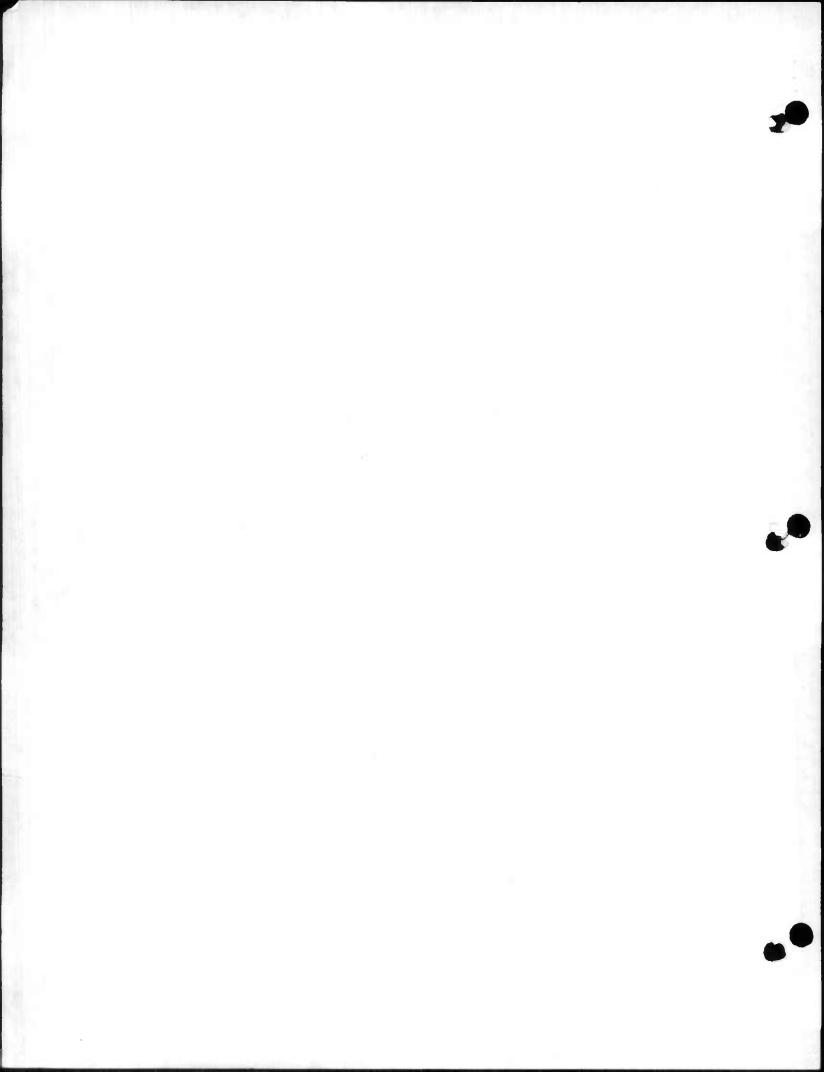
VOID
CERTIFICATE **

95-37326

SEE

CERTIFICATE **

95-37856



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27,28a-f, PER MEO FILM G-727 9/16/95 t.t

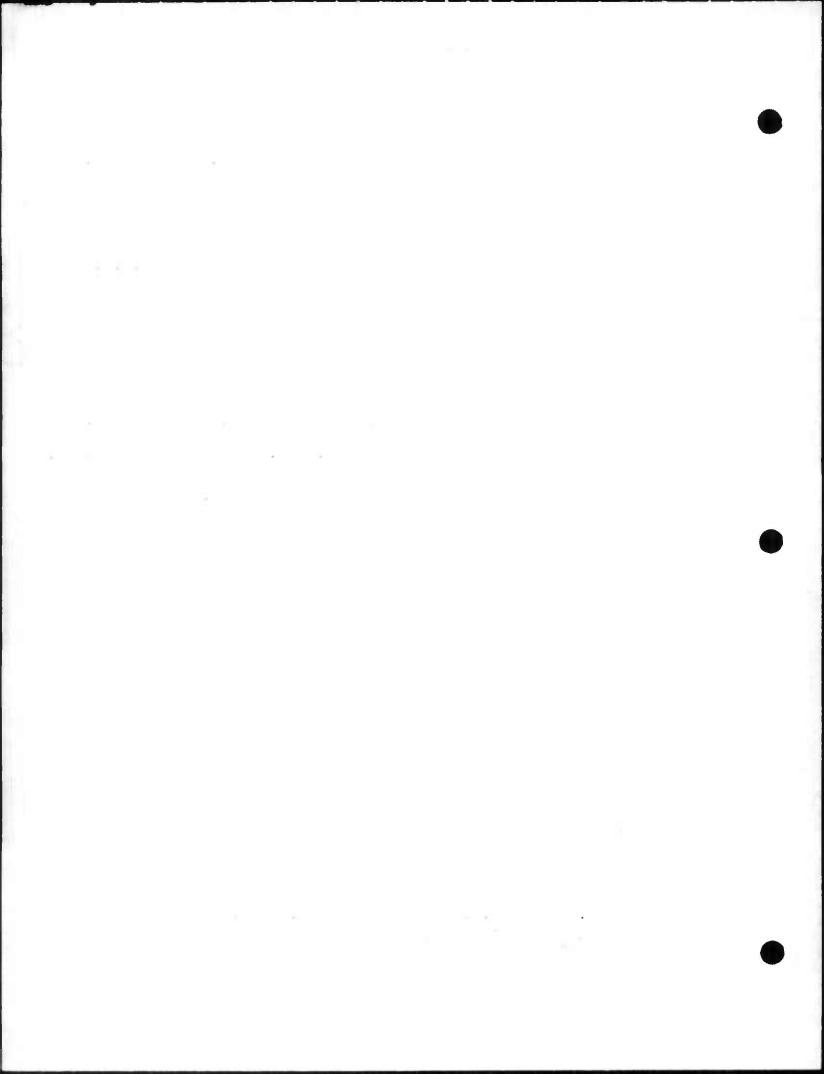
| | 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL HYGIEN REG. NO. | E | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------|--------------------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) WILLIE B. AND | ERSON | | | | 2. DATE OF DEATH MONTH SEPT. 6, | 1995 ^{AR} | 3. TIME OF DEATH 5:30 P. M | |
| | | | | | IF UNDER 24 HRS. | 2 DATE OF BIRTH | 0.000 | THPLACE (State or Foreign | |
| | | (XM 2 🗆 F | 45 YRS. | MONTHS DAYS | HOURS MIN. | APR. 15, 195 | | CAROLINA | |
| Œ | 9e. FACILITY NAME (If not institution, give street | and number) | | | OR LOCATION OF DE | ATH | 9c. COUNTY OF | DEATH | |
| СТОВ | 560 BAKER ST. | | | BALTI | | | 117 4 | | |
| DIRE | MARYLAND 10b. COUNTY | n/a | 10c. CIT | Y, TOWN OR LOCA BALTIN | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| ERAL | 100. STREET AND NUMBER 506 BAKER STRE | EET | | 10 | ZIP CODE 2121 | .7 | UNITE | D STATES | |
| BY FUNER | 11. MARITAL STATUS 1 Never Married 2 X Xerried 3 Widowed 4 Divorced | P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 ()(0 | If yea, ap | ENDENT OF HISPAI ecity Cuban, Maxica 2 (X) NO Specif | HC ORIGIN? (Specify Yea n, Puerto Rican, atc.) | 91 | CE — American Indian, lick, White, etc. | |
| ETED | 15. DECEDENT'S EDUCATI (Specify only highest grade con | ION noieted) | 16a, DECEDENT'S | USUAL OCCUPATION | ON ost of working | 16b, KIND OF BUS | SINESS/INDUSTRY | | |
| IPLET | | College (1-4 or 5+) | ROO | work done during mose retired.) FER | • | ROOF | ING CO | MPANY | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Last) ERNEST ANDERS | SON | | | | ME (First, Middle, Maiden ENE CROME | | | |
| TO B | 19a. INFORMANT'S NAME (Type/PAR) ANDERS | SON | 196. MAILING 1340 | | | , BALTIN | n, State, Zip Code) 10RE, MD | 21217 | |
| | 20a. METHOD OF DISPOSITION 16 Burlel 2 Cremetion 3 Remove 4 Densition 5 Char (Specify) | | PLACE AND DATE | | AL GARDE | | UNDALK, | Town, State MARYLAND | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIGHT | that | HH) | | C. MARCH | FH1101 | E. NOR | TH AVENUE | |
| | 23. PART fines the diseases, or conshock, or heart failure. Lia IMMEDIATE CAUSE (Final disease or condition resulting in death) | | ech line. | not enter the mo | ode of dying, aud | h aa cardiac or respi | ratory arrest, | Approximata Interval Between Onset and Death | |
| z | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents resulting in death) LAST | | | | | | | | |
| AL CE | PART II. Other significant conditions of | contributing to death b | out not resulting | In the underlyin | g cause given in | | | 4b. WERE AUTOPSY FINDINGS | |
| MEDICA | | | | | | PERFOI | | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | |
| | DID TOBACCO USE CONTRIE | BUTE TO CAUSE C | | | | N 🗆 | | | |
| PHYSICIAN: | | IOSPITAL: | 28. PLACE OF DEA | OTHER: | | 8 Other (Specify) | | | |
| HYS | 27. MANNER OF DEATH | 26a. DATE OF INJURY | 285 TIA | | JURY AT | 28d. DESCRIBE HOW | NJURY OCCURED | | |
| ВУ РІ | 1 Natural 5 Pending | (Month, Day, Year) FOUND: 9-6- | | | YES 2) NO | UNKNOWN | | | |
| 8 | 3 Suicide 6)(X) Could not be datermined | | a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) FOUND: RESIDENCE | | 281. LOCATION (Street and Number or Rural Route Number, City or Rown, State) 560 BAKER STREET BALTIMORE, MARYLAND | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | IN: To the best of my know | riedge, death occurr | red at the time, dat | | to the cause(a) and ma | nner as stated. | e(a) and manner as stated. | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 1 7 | | | 29c. LICENSE NU | | | ED (Month, Day, Year) | |
|) BE | Theodore In | 1. Koha | 12.1 | | O.C.M | | | 7,1995 | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO O | | 1 1 1 D 0 | o, Print) | et! Ba | ltimore, | | and 21201 | |
| | 31. DATE FILED (Month, Day, Year) SEP 1 1 1995 | 32 REGISTRAR'S SIG | ATURE | III SCL | | | | | |

| BALTIMORE, MARYLAND 21215-0020 | . OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physicis | DIRECTOR: After this perificate has been signed by the attending physician and completely filled in by the business attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended by the attended b |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Es hours after de | filled in hy the fur |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | law requires that the death certificate be executed within | has been signed by the attending physician and completely |
| DIVISION OF VITA | . OR ATTENDING PHYSICIAN: The | DIRECTOR: After this certificate h. |

r attending physician. use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the those TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

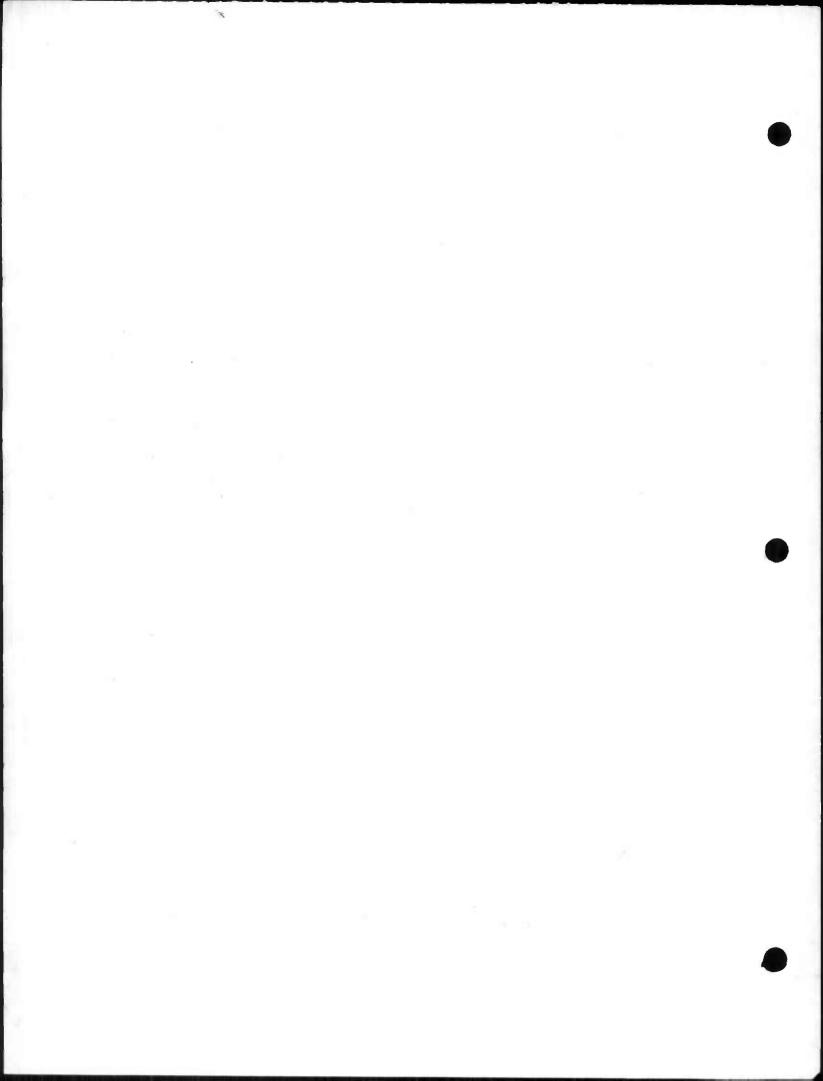
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYLAN | | MENT OF H | | MENTAL HYGIEI | | |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------|---------------------------------|--------------------|------------------------------------------------|----------------------|-----------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Joseph | Benson | | | | August : | 22,1995 | 5:50 AM M |
| | AND DESCRIPTION OF THE PROPERTY OF | 5. SEX 6. AGE (In y | rs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign |
| | 011 20 3330 | 1 🛛 M 2 🗆 F 7 1 | YRS. | MONTHS DAYS | HOURS MIN. | Sept. 14 | 1928 W | ash.,DC |
| | 9e. FACILITY NAME (If not institution, give stre | set end number) | | 9b. CITY, TOWN (| R LOCATION OF D | EATH | 9c. COUNTY OF | DEATH |
| DIRECTOR | 6101 East View | Street | | Bethes | da | | Montg | omery |
| E. | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| | | gomery | Bet | hesda | | | | 1 TES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | a | | 101 | ZIP CODE | | | WHAT COUNTRY? |
| NE | 6101 East View | | | | 20817 | | U.S | . A . |
| | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN U. FORCES? 1 X YES | 2 NO | If yes, sp | city Cuben, Mexica | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | Bla | E — American Indien, ck, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATE | S | 1 TYES | 2 NO Specif | y: | Spe | White |
| ED | 15. DECEDENT'S EDUCA (Specify only highest grade or | ATION 16 | ia. DECEDENT'S U | SUAL OCCUPATION | N | 16b. KIND OF BU | ISINESS/INDUSTRY | |
| E | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | ork done during mo retired.) | st of working | | | 5.0 |
| MP | 12 | | Owne | r | | Retai1 | Liquor | Store |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Melder | Surname) | |
| BE | Abraham Benson | | | | | Lenard | | |
| 2 | 19e, INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tox | | |
| | Shirlee Benson | | _ | | | eet, Bet | | |
| | 20e. METHOD OF DISPOSITION 1 N Burial 2 Cremetion 3 Remov 4 Donation 5 Other (Specify) | rel from State 20b.PL cemeter | ACE AND DATE OF | es place) M | me of | 8-23 Fal | CATION - City or 1 | own, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE NSEE | ng bav | | D ADDRESS OF FA | | .1s Chui | ch, Va. |
| | > mardam | D. Rus 6 | | Ives | -Pearso | on Funera | | 6 |
| _ | | | | | | ch, Va. 2 | | |
| | 23. PART I. Enter the dieeeses, or co shock, or heart fellure. Li | implications that caused the list only one cause on each | line. | _ | | | | Approximata Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | Make | Lt | - 1/ | note | 1 | | Onset and Death |
| l l | IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Due to (or as a consequence or: Due to (or as a consequence or: | | | | | | | Syren |
| - | _ | 202 10 (011 NO X 00 | MOLOULINGE OF) | • | | | | |
| 5 | Sequentielty list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 3 | cause, Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | |
| E | that initiated evente | DUE TO (OR AS A CO | INSEQUENCE OF) | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | |
| AL C | PART II. Other significant conditions | contributing to death but i | not resulting in | the underlying | ceuse given in | Part I. 24s. WAS AF | AUTOPSY 24 | b. WERE AUTOPSY FINDINGS |
| S | | | | | | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 빌 | | | | | | 1 □ YES | , Ki wo | OF DEATH? 1 YES 2 NO |
| ä | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF I | DEATH YES | | UNCERTAIL | <u>v [v</u> | | 1 160 2 100 |
| SIA | 25. WAS CASE REFERRED TO MEDICAL | 26. | PLACE OF DEATH | (Check only one) | | | | |
| YSI | 1 TYES 2X XNO | HOSPITAL; 1 - Inpatient 2 - ER/Outpatie | | OTHER: Nursing Home | 5 TResidence | 8 Other (Specify) | | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH | 28+. DATE OF INJURY (Month, Day, Year) | 28b, TIME INJU | OF 28c. INJI | | 28d. DESCRIBE HOW | INJURY OCCURED | |
| ВҰ | 1 Natural 5 Pending 2 Accident Investigation | | | | ES 2 NO | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, ferm, str | eet, factory, office | | 28f. LOCATION (Street City or Town, State | | Route Number, |
| COMPLET | 29e. CERTIFIER | | | | | | | |
| MPL | (Check only 1 CERTIFYING PHYSICI | AN: To the best of my knowledg | e, death occurred | st the time, date | end place, end due | to the cause(e) end me | nner ee stated, | |
| 00 | | On the basis of examination on | d/or Investigation, | In my opinion, de | eth occured at the | time, date and place, er | nd due to the cause(| e) end manner ee stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIED | 1/1 | manusco e | | 29c. LICENSE NUM | MER | 29d. DATE SIGNE | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON AND | | | | D3329 | 3 | Augus | st 22, 1995 |
| | Frederick P. Smi | | | | Ave. Wa | ish no 2 | 0015 | |
| | 31. DATE FILED (Month, Day, Year) | | | SECTIF . | ve., wa | . J. H. J. D. C. | .0013 | |
| | SEP11 1995 | A REGISTRAR'S SIGNATE | ardall | | | | | |



31. DATE FILED (Month, Day, 1995) SEP 1 1 1995

| ITEMS: 23 PART FOR STATE | I, 27, PER ME | ARYLAND / DE | PARTMENT (| OF HEALTH AND | MENTAL HYGIEN | | | 6136 | |
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| REGISTRAR 1. DECEOENT'S NAME (First, Middle, THOMAS | Lest) | CERT | BROWN | OF DEATH | 2. DATE OF DEATH SEPT. 04 | | 9 ^{YEAR} | 3. TIME OF DEATH | n Am |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 3. AGE (In yrs, lest birth | nday) IF UNDER 1 Y | | 7. DATE OF BIRTH (Month, Dev. Year) JAN 17,19 | Т | 8. BIRTI Count | NPLACE (State or For | reign |
| 99. FACILITY NAME (If not institution 433 E. LANVAL RESIDENCE OF DECEDE | E STREET | | | OWN OR LOCATION OF DI | EATN | 9c. COU | | DEATH | |
| 10e. STATE 10b. C | N/A | 100 | Balti | more | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 | |
| 10e. STREET AND NUMBER 433 E. Lanvale 11. MARITAL STATUS 1 N Never Merried 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT | EVER IN U.S. ARMED VES 2 NO | If y | 10f. ZIP CODE 21202 \$ DECENDENT OF NISPAI ss, specify Guben, Mexico VES 2 NO. Section | in, Puerlo Rican, etc.) | U. | S.A. | E — American India | in, |
| 15. DECEDENT (Specify only highest Elementery/Secondary (0-12) 12th 17. FATNER'S NAME (First, Middle, Li | S EDUCATION t grade completed) College (1-4 or 5+) | 16e. DECEDE (Give kli life. Do fi | ENT'S USUAL OCC and of work done dur NOT use retired.) | ing most of working | TOP TEM | PORAR | USTRY | Black | |
| Thomas Brown, 190. INFORMANT'S NAME (Type/Print Thomas Brown, | 1) | | | Pearl Watson LINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 McElderry Street/Baltimore, MD 21205 | | | | | |
| 20a. METNOD OF DISPOSITION 1 M Burlel 2 Cremetton 3 4 Donatton of Other (Specification 2) 21. SIONATURE of FUNERAL SERV 23. PAROL Error two diseases shock, or heart fer immediate CAUSE (Finel disease or condition resulting in death) | a, or complications that flure. List only one caus | coused by country crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory crematory cremator | Memoria 22. NA MAI 11 (| al Gardens ME AND ADDRESS OF FA RCH FUNERAL DI E. NORTH | 9-12 Du HOME EAST AVENUE/Ba | r altimo | ore, | D | tte etweer |
| Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evanta Due to (or as a consequence of): | | | | | | | | |
| PERFORMED? YES 2 NO NO NO NO NO NO NO NO NO NO | | | | | | | | b. WERE AUTOPSY FII AWAILABLE PRIOR COMPLETION OF C OF DEATN? | TO |
| DID TOBACCO USE C 25. WAS CASE REFERRED TO MED EXAMINER? 1 (2) YES 2 NO | CAL HOSPITAL: | | YES NO | y one) | | | | | |
| 27. MANNER OF DEATN 1 XX Natural 5 Pendin 2 Accident Investi | BC. INJURY AT WORK? 1 YES 2 NO | e 6 Other (Specify) 28d. OESCRIBE NOW INJURY OCCUREO | | | | | | | |
| 3 Suicide 6 Could 4 Nomicide determ 29e. CERTIFIER (Check only 1 CERTIFYING | pnysician: To the beat of r | | occurred at the tim | e, date end place, end du | | nner ee sta | led. | | |
| 29b. WONATURE AND TITLE OF CI | 296. LICENSE NUMBER 296. LICENSE NUMBER O . C . M . E . 296. LICENSE NUMBER O . C . M . E . 297. DATE SIGNED (Month, Day, Year) September 4, 19 | | | | | | | | |



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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO |). | | | | |
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| 1. DECEDENT'S NAME (First, Middle, Last) | Blanche | BISH | 1OP | | 2. DATE OF DEATH | MY YEAR | 3. TIME OF DEATH 2:50 am | | | |
| 4. SOCIAL SECURITY NUMBER 2. 9-12-6597 90. FACILITY NAME (If not institution, give | 1 🗆 M 2 F | AGE (In yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Year) | 915 Vi | THPLACE (State or Foreign ntry) | | | |
| Saint Joseph Med | dical Center | | | SON, MAR | | ec. COUNTY OF | | | | |
| 100. STATE 10b. COUNT | Altimor | 10c. CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? | | | |
| 300 E. PEN | noulua | nia A | 10 W. | . ZIP CODE | 286 | 10g. CITIZEN OF | 1 YES 2 NO | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS PECEDENT EV FORCES? 1 1 IF YES, GIVE WAR O | YER IN U.S. ARMED | 13. WAS DEC | ENDENT OF HISPA ecify Cuben, Maxic 2 NO Speci | NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) | Ble | CE — American Indian, lock, White, etc. | | | |
| 15. DECEDENT'S EDU (Specify only highest grade | le completed) | (Give kind of | USUAL OCCUPATION Work done during mose retired.) | ON ast of working | 16b. KIND OF BU | SINESS/INDUSTRY | | | | |
| 11th grade | Elementary/Secondary (D-12) College (1-4 or 5+) OFFICIAL COLLEGE (1-4 or 5+) OFFICIAL COLLEGE (1-4 or 5+) OFFICIAL COLLEGE (1-4 or 5+) | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | JENKIN | S | | 18. MOTHER'S N. | AME (First, Middle, Melder | Sumame) | ld | | | |
| 19a. INFORMANT'S NAME (Type/Print) | 441-1160 | 19b. MAILING | AOORESS (Street | nd Number or Rural | Route Number, City or Tox | vn, State, Zip Code) | 23139 | | | |
| 20e. METHOD OF DISPOSITION 20e. METHOD OF DISPOSITION 30b. PLACE AND DATE OF DISPOSITION (Name of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of grant of gr | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LI | JL . | MOIN | 22. NAME AI | ND ADDRESS OF F | ACILITY 50 YO R | CISTUS | four les m | | | |
| 23. PART I. Enter the diseases or | Fomplications that co | used the death. Do | CHA | TMAN-H | oms + N. | Silhai | Approximate | | | |
| ahočk, or heart fállure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | METASTA | TIC CARCIN | IOMA OF | | | | Onset and Deat YEARS | | | |
| DUE TO (OR AS A CONSEQUENCE OF): CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | ause. Enter UNDERLYING AUSE (Disease or Injury hat Initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant condition | PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | |
| 24b. WE SAN AUTOPSY PERFORMED? 1 YES 2 NO 1 | | | | | | | | | | |
| DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAUS | E OF DEATH YE | | UNCERTAI | N 🗆 | | | | | |
| EXAMINER? | HOSPITAL: | | OTHER: | e 5 🗆 Residence | 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Vistural 5 Pending Investigation | 26a. DATE OF INJU (Month, Day, Ye | | E OF 28c. INJ | | 28d. OESCRIBE HOW | NJURY OCCURED | | | | |
| 3 Suicide 8 Could not be detarmined | 2 Accident 3 Suicide 8 Could not be building ste (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, | | | | | | | | | |
| | (Check only 1 OERTIFTING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIE | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WE | 10 COMPLETED CAUSE OF | RK ROAD TO | Print) DWSON.M | MRYLAND | 21204 | | | | | |
| SEP 11 199 | 12 DECIGTRADE | | | | | | | | | |

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METASTATIC CARCINONA OR THE LUNG. CEREBROVASCULAR ACCOENT

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LILA CEBALLOS NO TREO YORK ROAD TOWSON MARYLAND 2/204

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior tremation, or removal.

IMPORTANT: If than 28 is marked, or them 23 shows any injury or offer transmatte event. The medical examiner must be neitfilled at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | MENTAL HYG | | | |
|---------------|------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|--------------------|--------------------------------|-------------------------------------------------|-----------------|---------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEAT | 'N | 3. TIME OF DEATH | |
| 1 1 | WILLIAM B | BRADDS JR. | RADDS JR. | | | | 04,19 | 95 1320 PM | |
| | | SEX 6. AGE (In | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yel DEC. 4, | 4 8 nr) | BIRTNPLACE (State or Foreign Country) Marvland | |
| | 9e. FACILITY NAME (If not institution, give street | ` | | b. CITY, TOWN C | R LOCATION OF DE | | | Y OF DEATH | |
| DIRECTOR | 209 SOUTH PARRIS | SH STREET | 2ND.FL. | BALTI | MORE C | TY | | N/A | |
| <u> </u> | 10e. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCAT | TION | - | | 10d, INSIDE CITY | |
| | Md. N/A | | Bal | timore | | | | 1 X YES 2 NO | |
| FUNERAL | 3061 Stafford St. | | | 101 | 21223 | | | IN OF WHAT COUNTRY? | |
| S | 11. MARITAL STATUS 12 | . WAS DECEDENT EVER IN I | U.S. ARMED | | ENDENT OF HISPAN | | y Yee or No 1 | 4. RACE — American Indian, | |
| ВУ Е | 1 Never Married 2 X Merried 3 Widowed 4 Divorced | FORCES? 1 YES | ES NO | | 2 NO Specify | | i.) | Specify: White | |
| TED | 15. DECEDENT'S EDUCATI (Specify only highest grade con | npleted) | 16e. DECEDENT'S US (Give kind of work life. Do NOT use n | done during mo | ON st of working | 16b, KIND O | F BUSINESS/INDU | STRY | |
| COMPLET | Elementery/Secondary (0-12) C | Offege (1-4 or 5+) | | Worked | | Neve | r Worke | d | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | IV/A | | | | ME (First, Middle, Mi | | - | |
| BEC | William M. E | Bradds, Sr. | | | Donn | a Church | 1 | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | 1 | | nd Number or Rural I | | | , | |
| | William M. Bradds | | | | St., Ba | | | | |
| | 20a, METHOD OF DISPOSITION 1 | | PLACE AND DATE OF I tery, grematory or other COOWTIGE | | | | Location — ci | | |
| | 21. SIGNATURE OF THE L SERVICE LICENS | SEE /// | 0/ | | ADDRESS OF FA | | al Homo | of Elk., Inc. | |
| | 1 Duyc Z | _ au | X | | Main St. | | | | |
| | 23. PART I. Enter the diseases, or com shock, or heart failure. List | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | 7.01 | | | Onset and Death | |
| | disease or condition NARCOTIC AND COCAINE INTOXICATION | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | ., | | | | |
| FR | resulting in death) LAST | | | | | | | | |
| | PART II. Other algnificant conditions of | contributing to death bu | t not resulting in | the underlyin | g causa given in | Part I. 24s. W | AS AN AUTOPSY | 24b, WERE AUTOPSY FINDINGS | |
| SICAL | | | | F10 | | | RFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| MEDIC | | | | | | _ | | OF DEATH? | |
| NN: N | DID TOBACCO USE CONTRIB | BUTE TO CAUSE OF | DEATH YES | □ NO □ | UNCERTAIL | 10 | | | |
| PHYSICIAN: | | OSPITAL: | 6. PLACE OF DEATN | (Check only one) | | | | | |
| IXS | 1 X YES 2 NO 1 | ☐ Inpatient 2 ☐ ER/Outpar | tient 3 DOA 4 | | ne 5XX esidence | | OW INJURY OCCU | IDED | |
| | 1 Netural 5 Pending | (Month, Day, Year) 9-4-95 | UNKNO | Y WC | YES 2 XXNO | UNKNOWN | IOW INSORT COCC | THE O | |
| | 2 Accident Investigation 3 Suicide 6 XXCould not be | 25e. PLACE OF INJURY - building, atc. (Specif | — At home, ferm, stre | et, fectory, offic | :0 | | | r Rurel Route Number, | |
| TE | 4 Homicide determined | ballating, and Copoun | " HOUSE | | | BALTIMORE | | . PARRISH ST. | |
| COMPLETED | Check only ———— | N: To the best of my knowle | | | | | | d. ceuse(e) and menner se stated. | |
| | 29b. MIGNATURE AND TITLE OF CENTIFIER | | | artiny opinion; | 29c. LICENSE NUI | | | SIGNED (Month, Day, Year) | |
| | (1) asomber | Lo M |) | | O.C.N | | | PT. 05,1995 | |
| D 0 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETED CAUSE OF DEA | TN (ITEM 27) (Type, P | rint) | 0.0.1 | 4 • 14 | | | |
| | JLA RON COCKE 31. DATE FILED (Month, Day, Shak) | | | Stree | t, Balt | imore, | Maryl | and 21201 | |
| | SEP1 1 1995 July | 37 REGISTRAR'S GNA | all | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| DING | After | deat | S m |
| NITEN | CTOR | after | 28 |
| . DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1. | hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | | | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 573 SILVA " Brooks 1-2 H 4. SOCIAL SECURITY NUMBER April 1 16, 19 7 Country) 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign 88 DAYS 1 M 2 X F 228 52 8917 Iowa 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 14715 Lindsey Lane Silver Spring Montgomery RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 X NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20910 14715 Lindsey Lane U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Block, White, stc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married ВУ Specify: White 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retred.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker own home 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) George F. Heindel BE Emma Reinhard 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Marshall H. Brooks 201 South Lee Street, Alexandria, Va. 22314 20a. METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 Ren
4 Denation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Metropolitan Crematory Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes le c 2847 Wilson Blvd., Arlington, Va. 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between ahock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition_ resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Home 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED Netural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated, 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE)3P 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

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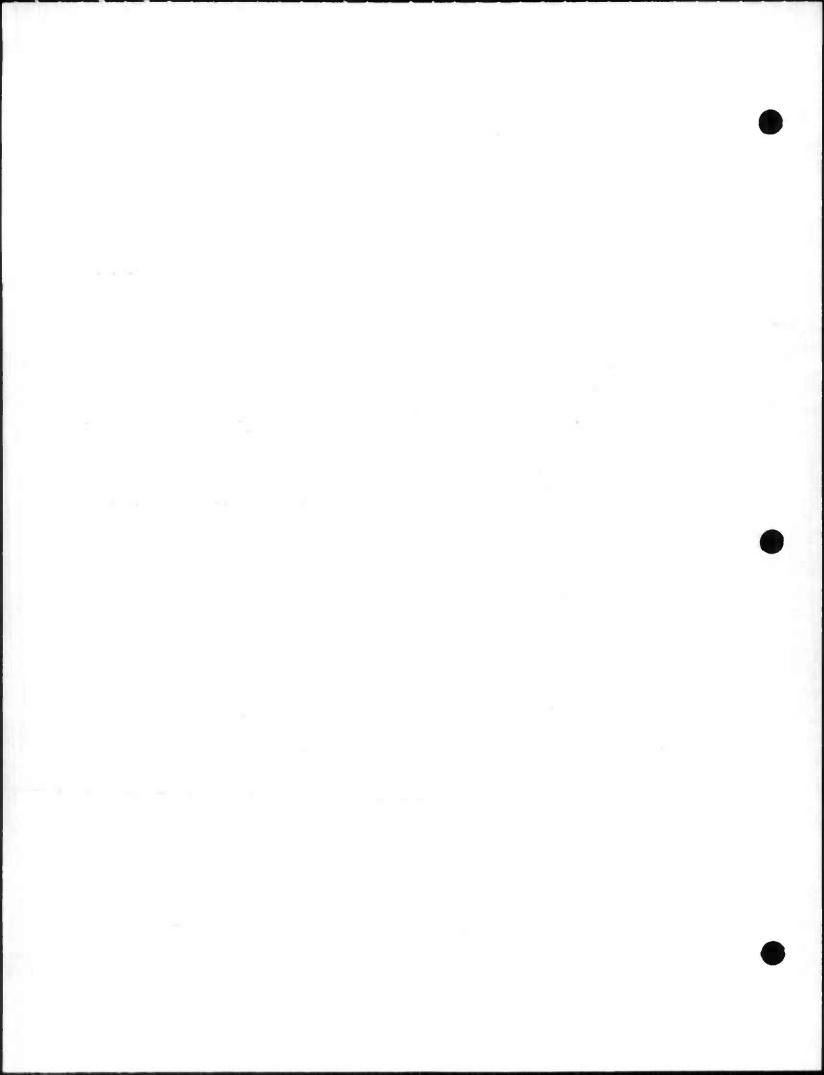
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31. DATE FILED (Month, Day, Year) SEP 1 1 1995

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IMPORTANT: If It



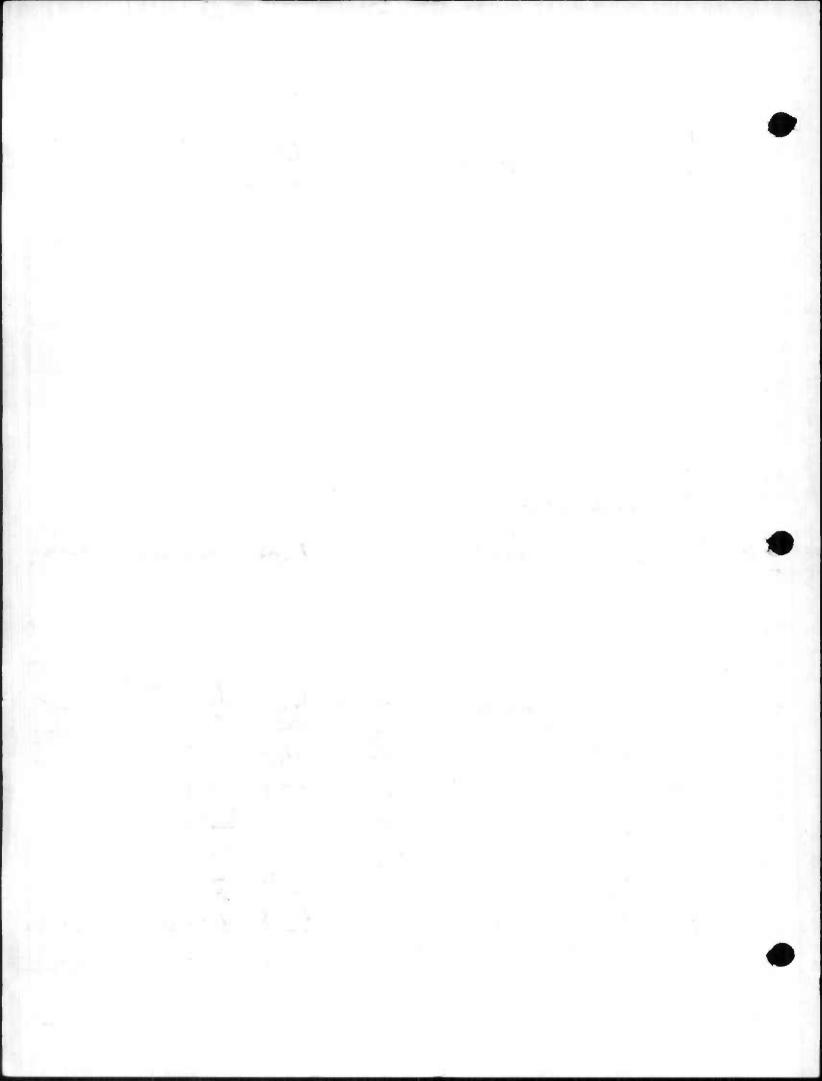
its after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769, ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

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| | 219-10-3135 90. FACILITY NAME (If not institution, give | 10 M 2 0 F 9 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 12 07 19 | Coun | yland | |
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| DIRECTOR | Maryland Balti | * | - | ry, town or locat WSON | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 509 E. Joppa Roa | ıd | | 1.25 | 21286 | | U.S.A | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | | NIC ORIGIN? (Specify Warn, Puerto Rican, atc.) by: | ee or No— 14. RAC Blac Spe | E — American Indian, ck, White, etc. city: White | |
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| BE COM | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S NA | AME (First, Middle, Malde | on Surneme) | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) James Frederick Offutt | | 195. MAILING 105 W SULLE | Chesap | eake Ave son. Mar | Poute Number City or To NUE-JEGGE Yland 21 | TSON ZIOCOCO) 204 | ding- | |
| | 20e. METHOD OF DISPOSITION 1 | movel from State of c | emetary, cremator | | | | OCATION City or 1 | own, State | |
| 7 | Amany M | Marce | | State Rm. BO | 26-Balti | Board-65! | iland 21 | imore Street 201-1559 | |
| | 23. FART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. List only one cause on as | the dath. Do ach line. | not entar the mo | ode of dying, such | eh as cardiac or rea | piratory arrest, | Approximate interval Between Onset and Death | |
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| 4 | PART II. Other significant condition | one contributing to death be | ut not resulting | In the underlyin | g cause given in | SO MARK | AN AUTOPSY 24 ORMED? | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: MEDICA | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | |
| HYSIC | EXAMINER? 1 YES 2 DATE OF INJURY 27. MANNER OF DEATH 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE O | | | | | | | | |
| BY | Natural 8 Pending INJURY WORK? M 1 YES 2 NO No No No No No No | | | | | | | | |
| COMPLETED | Torroom orm | SICIAN: To the best of my knowl | - 31197 | | | | | (s) and manner as stated | |
| BE CO | 29 SIGNATURE AND TITLE BY CENTER | 7 | ^ | | 29c. LICENSE NU | | | D (Month) Day, Marr) | |
| 9 | 36. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Typ | ea, Print) | 441 | R. Cara | Dr to | 2 Al Marion | |
| | 31. DATE FILED (Month, Day, Year) SFP11 1995 | 37. BEGISTRAR'S SIGN. | ATTION | 5 | 17 | Bestov | 2D 3 | W DU LOL | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| may be retained by the hospital or attending physician. | page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | be notified at once. |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 may be | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notifi |
| TO THE HOSPIT | TO THE FUNER | be filed within 7 | IMPORTANT: |

| | Item#1. 3-fi | lm 727 per | F,H 9/ | 18/95 E | P.C | | | 1. 100 |
|---------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------|-------------------------------|---------------------------------|-------------------------------------------------------------------------------------|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYI | | TMENT OF | | | GIENE G. NO. | |
| | | TON CUTC | | | | 2. DATE OF DE | | YEAR 995 11 , 20 P M |
| TOR | 4. SOCIAL SECURITY NUMBER 212-38-1325 | 1 DXM 2 🗆 F 55 | (In yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIF (Month, "7 | | 6. BIRTNPLACE (State or Foreign Country) Md |
| | 98. FACILITY NAME (If not institution, give St. Agnes Hos RESIDENCE OF DECEDENT | | | | or Location of D | | 9c. COU | N/A |
| DIRECTOR | 10a. STATE 16b. COUNT | | | v, town or Local | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| BY FUNERAL | 10e. STREET AND NUMBER 6003 Central A | | | 10 | r. ZIP CODE | 7 | | IZEN OF WHAT COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Vidowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D | IN U.S. ARMED | 13. WAS DE If yes, s | CENDENT OF NISPA pecify Cuben, Mexico S 2 NO Specif | an, Puarlo Rican, | cify Yes or No- | 14. RACE — American indian, Black, White, atc. Specify: |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elamentary/Secondary (0-12) | UCATION le completed) College (1-4 or 5 +) | 18a. DECEDENT'S (Give kind of life. Do NOT us | USUAL OCCUPATI work done during m se retired.) | ON ost of working | 16b. KIND | OF BUSINESS/INC | White |
| COMPL | Grade 12 17. FATNER'S NAME (First, Middle, Last) | | Fire | nan | 18. MOTNER'S NA | Ba. | | e County |
| TO BE | Harry H | Cutcher | 19b. MAILING | ADDRESS (Street | Alv | erta 4 Route Number, City | | THIEL Code) |
| | Pearl A Cutc 20a. METNOD OF DISPOSITION 1 XBurdal 2 Cremelion 3 Ram | noval from State | b. PLACE AND DATE | OF DISPOSITION (N | ame of | DATE | 20c. LOCATION — | Md. 21207 City or Town, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI | N | leadowr | dge Me | m.Pk.C ND ADDRESS OF FA Balti | CILITY | | oward Co.,Md, |
| | 23. PART I. Enter the diseases, or | Schwah | ed the deeth. Do | Bald | imore. | Md. 2 | 1229 | reat, Approximate |
| | IMMEDIATE CAUSE /Float | a. UPPER | | SLEED | 1269 | | | Interval Between Onset and Death |
| NC | Sequentially liet conditions, | DUE TO (OR AS | SIS 0 | n: F LIV | - | | | menths |
| CERTIFICATION | If any, leeding to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events | · ALCOHO | A CONSEQUENCE OF | | | | | Years |
| CERTI | resulting in death) LAST | d | | | | | | |
| MEDICAL | PART if. Other algnificent condition | a contributing to death i | but not resulting | in the underlyin | g ceuse given in | 1 | PERFORMED? YES 2 TO NO | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| AN: M | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | OF DEATH YE | | | N 🗆 | | 1 TES 2 NO |
| BY PHYSICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | ne 5 🗆 Rasidence | 6 Other (Spec | ffy) | |
| | 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b, TIM INJ | URY W | JURY AT ORK? YES 2 NO | 28d. DEŞCRIBE | NOW INJURY OCC | CURED |
| ED | 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, atc. (Spe | Y — A1 home, farm, i | street, factory, offic | | 281, LOCATION City or Town | (Street and Number o, State) | or Rural Route Number, |
| COMPLET | | ER: On the beat of my know | | | | | | ed. e cause(a) and manner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | ux oppe | / | | 29c. LICENSE NUI | - | 29d. DATE | 9 (8) 95 |
| 5 | 30. NAME AND ADDRESS OF PERSON WH | | EATN (ITEM 27) (Type, | Print) | T (11-1 | vsnz e v n | 126 | 3 20504 - |



SEP 1 1 1995

. . . BALTIMORE, MARYLAND 21203-3146
ter death. Page 6 may be retained by the hospital or attending physician.
the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

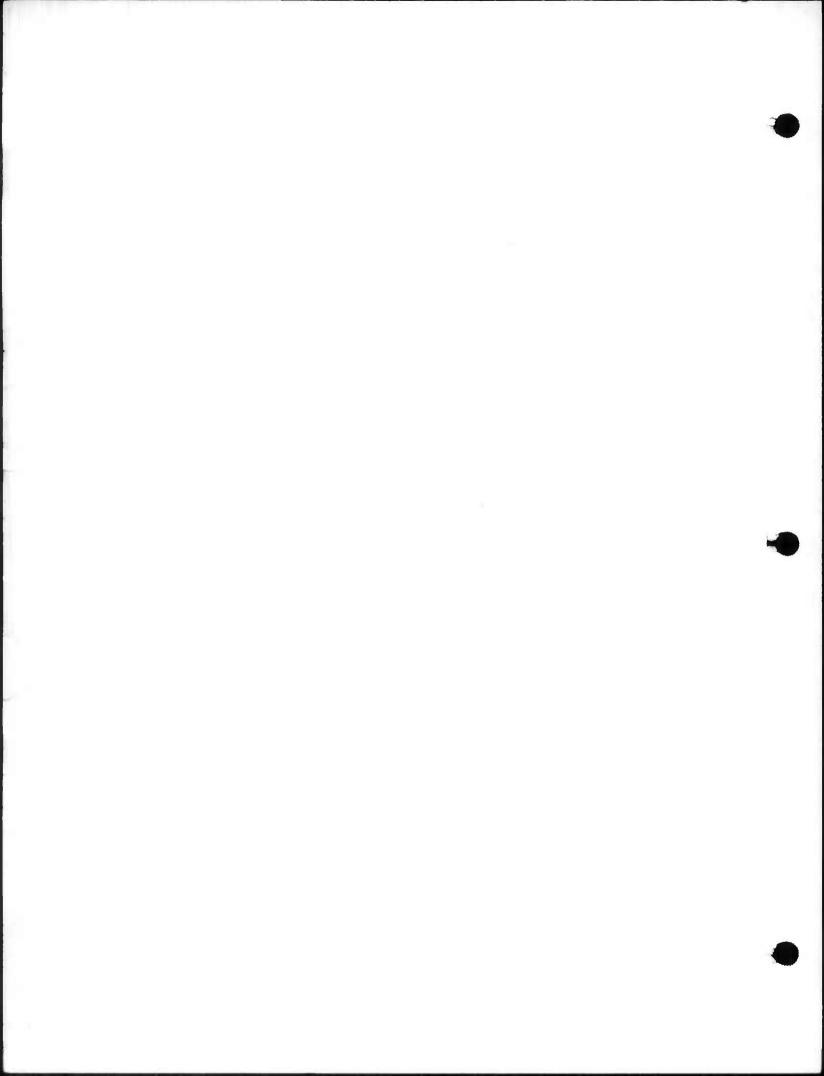
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 cours after death. Page 6 may be retained by the hosp TRECTOR: After this certificate has been signed by the attending physician and completely fills of the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bridly, cremation, or removal. **INDICATE THE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABLE THE TABL | 3 |
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| = | E |

31. DATE FILEO (Month, Day, Year)

| | 1 - STATE OF STATE OF | | RTMENT OF HEALTH AN | D MENTAL HYGIEN | E | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|-----------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | 02 | // | 2, DATE OF DEATH | | TIME OF DEATH | | |
| | Barbara Duni | ab Chan | ndler | Depleruped 1 | 1995 | 630X) M | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. last birthday | | S. DATE OF BIRTH | 6. BIRTHPL. Country) | ACE (State or Foreign | | |
| | 552-18-4228 1□ M 2 😾 | 76 YRS. | MONTHS DAYS HOURS M | 01-21-19 | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION O | F DEATH | 9c. COUNTY OF DEA | тн | | |
| OR | 9116 Saint Andrews Place | 2 | College Park | | Prince Ge | orge's | | |
| <u> </u> | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10c. C | ITY, TOWN OR LOCATION | | 10 | Od, INSIDE CITY | | |
| DIRECTOR | Maryland Prince George | 2's | ollege Park | | 1 | LIMITS? | | |
| | 10e. STREET AND NUMBER | | 101. ZIP CODE | | 10g. CITIZEN OF WH | AT COUNTRY? | | |
| FUNERAL | 9116 Saint Andrews Place | 2 | 20744 | | U.S.A. | AV | | |
| | FORCESS | DENT EVER IN U.S. ARMED 1 YES 2 NO | | SPANIC ORIGIN? (Specify Yea xican, Puarto Rican, atc.) | or No — 14. RACE — Black, V | - American Indian, Vhita, etc. | | |
| B√ | | E WAR OR DATES | | pecify: | | white | | |
| | 15. DECEDENT'S EDUCATION | 15a DECEDENT | 'S USUAL OCCUPATION | 165 KIND OF BUI | I SINESS/INDUSTRY | | | |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 o | (Give kind o | f work done during most of working use retired.) | | | | | |
| COMPLETED | 12 5+ | | iteer worker | Human S | ervices | 7590 | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | | 18. MOTHER | NAME (First, Middle, Maiden | Sumame) | | | |
| BE (| Albert Menzo Dunlap | | Eva (|)yman | 17 | 5 10 V | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | NG ADDRESS (Street and Number or R | | | 00010 | | |
| | Jim Chandler 20a, METHOD OF DISPOSITION | | 1st. Avenue-S | 7 | | | | |
| | 1 Burial 2 Cremation 3 Ramoval from State other place) 4 X Donation 5 Other (Specify) | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ROnald Wade, Dir. 22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street | | | | | | | |
| | anaul / W | ale . | Rm. B026-Bali | imore, Mary | land 2120 | 1-1559 | | |
| | 23. PART . Enter the diseases, or compilications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one cause on each line. | | | | | | | |
| | Onset and Death | | | | | | | |
| | disease or condition resulting in death) | | | | | | | |
| | DUE | TO (OR AS A CONSEQUENCE | OF): | | | | | |
| CERTIFICATION | Sequentially list conditions, DUE | | | - | | | | |
| ZAT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | |
| Ē | that hilliaten events | TO (OR AS A CONSEQUENCE | OF): | | | | | |
| E | resulting in death) LAST | | | | | | | |
| | PART il. Other significant conditions contributing | to death but not resultin | g in the underlying cause give | in Part i. 24s. WAS AN | AUTOPSY 24b. W | PERE AUTOPSY FINDINGS | | |
| MEDICAL | Surgrouply removed & | enign tumor | SP Sylon | PERFO | C | VAILABLE PRIDE TO OMPLETION OF CAUSE | | |
| 밀 | Lateration, 105 mand suy | · Soupetal / | USIMI | | | F DEATH? | | |
| | Plat a colitie newstra success, oderan onelly | | | | | | | |
| M | 25. WAS CASE-MEFERRED TO MEDICAL EXAMINER? | 1 1) | 26. PLACE OF DEAT | (Check only one) | | | | |
| SIC | 1 de YES 2 de NO de la Impatient | 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Realde | nce 6 - Other (Specify) | | | | |
| PHYSICIAN: | | | IME OF 28c. INJURY AT WORK? | 28d, OEŞCRIBE HOW | INJURY OCCUREO | | | |
| B≼ | 2 Accident Investigation | | M 1 YES 2 NO | | | | | |
| | | 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or lown, State) | | | | | | |
| | 3 Suicide 6 Could not be 28e. PLAC | E OF INJURY — At home, familing, etc. (Specify) | | City or Town, State |) | | | |
| | 3 Suicide 6 Could not be determined 28e. PLAC build | ing, etc. (Specify) | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | ing, etc. (Specify) | urred at the time, data and pieca, and | due to the cause(a) and ma | nner as stated. | ind manner as stated. | | |
| E COMPLETED | 3 Suicide 6 Could not be determined 25e. PLAC build 29e. CERTIFIER (Check only | ing, etc. (Specify) | urred at the time, data and placa, and ation, in my opinion, death occured a 29c. LICENSI | due to the cause(a) and ma t the time, date end place, el | nner as stated. | | | |
| COMPLETED | 3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis | ing, etc. (Specify) It of my knowledge, death occur of axamination and/or investiga | urred at the time, data and place, and stion, in my opinion, death occured a 29c. LICENSI D 2 1 | due to the cause(a) and ma | nner as stated, nd due to the cause(e) e | | | |

32. REGISTRAR'S SIGNATURE



| | 1. DECEDENT'S NAME (First, Middle, Leet) | 2. DAT | REG. NO. | | 3. TIME O | F OEATH |
|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------|---------------------------|---------------------------------------------------------|-------------------------|
| | Ralph Alexander Davis | 08 | -28-95 | AY . | 3: | 46 a. |
| | 4. SOCIAL SECURITY NUMBER 220-01-0333 5. SEX 1 M 2 F 76 9RS. 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR IF UNDER 24 HR PRS. MONTHS DAYS HOURS MIN | s. 7. DATI | OF BIRTH (th, Day, Year) -29-19 | | BIRTHPLACE (State Country) Maryland | |
| 10R | 98. FACILITY NAME (If not Institution, give street and number) 9410 52nd Avenue College Park | | | 9c. COUNT | ry of DEATH | ae's |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's College Park | | | | 10d. INSIE | E CITY |
| FUNERAL | 100. STREET AND NUMBER 9410 52nd Avenue 101. ZIP CODE 20740 | | | 10g. CITIZI | N OF WHAT COUN | |
| B | 11. MARITAL STATUS 1 | xican, Puerto | | or No- | 4. RACE — Americ Black, Whita, etc Specify: White | en Indien, |
| PLETED | 15. OECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1. Out-line 15. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16 | Music, | | stry employed | d |
| E COMP | 12th Piano Technician 17. FATHER'S NAME (First, Middle, Last) Ralph Alexander Davis, Sr. Hazel | NAME (FIG.), Houde | Middle, Maiden Shel | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Anna Davis 190. MAILING ADDRESS (Street and Number or Ru 9410 52nd Avenue-Col | rel Route Nur | Park, 1 | n, Store, Zie C Marylo | ind 20 | 740 |
| | 20a. METNOO OF DISPOSITION 1 | OA | TE 20c. LO | CATION — CI | ty or Town, State | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSER Ronald Wade, Dir. 22. NAME AND ADDRESS OF State Anatom Rm. B026-Balt | ny Boa | | | eltimore 21201- | |
| CERTIFICATION | 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, a shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | inter | rval Batwe |
| MEDICAL CE | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given | in Part I. | 24a. WAS AN PERFOR 1 YES 2 | MED? | 24b. WERE AUTO AMAILABLE COMPLETIC OF DEATH? | PRIOR TO ON OF CAUSE |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERT. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | AIN 🗆 | | | | |
| Sic | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residen | ce 6 🗆 Oth | er (Specify) | | | |
| 5 0 | 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY WORK? 1- Netural 5 Pending 28c. INJURY AT WORK? | | SCRIBE NOW IN | JURY OCCU | RED | |
| | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, tactory, office building, atc. (Specify) | | CATION (Street a or Town, State) | nd Number or | Rural Route Numbe | ν, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and cone) 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at | | | | | or an stated. |
| BE | 296. SIGNATURE AND THE OF CERTIFIER Q. SSQ DA DU | | 1 | | 130 99 | |
| TO BE | () | | 3 | 29d. DATE S | 130 99 |) Yes |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

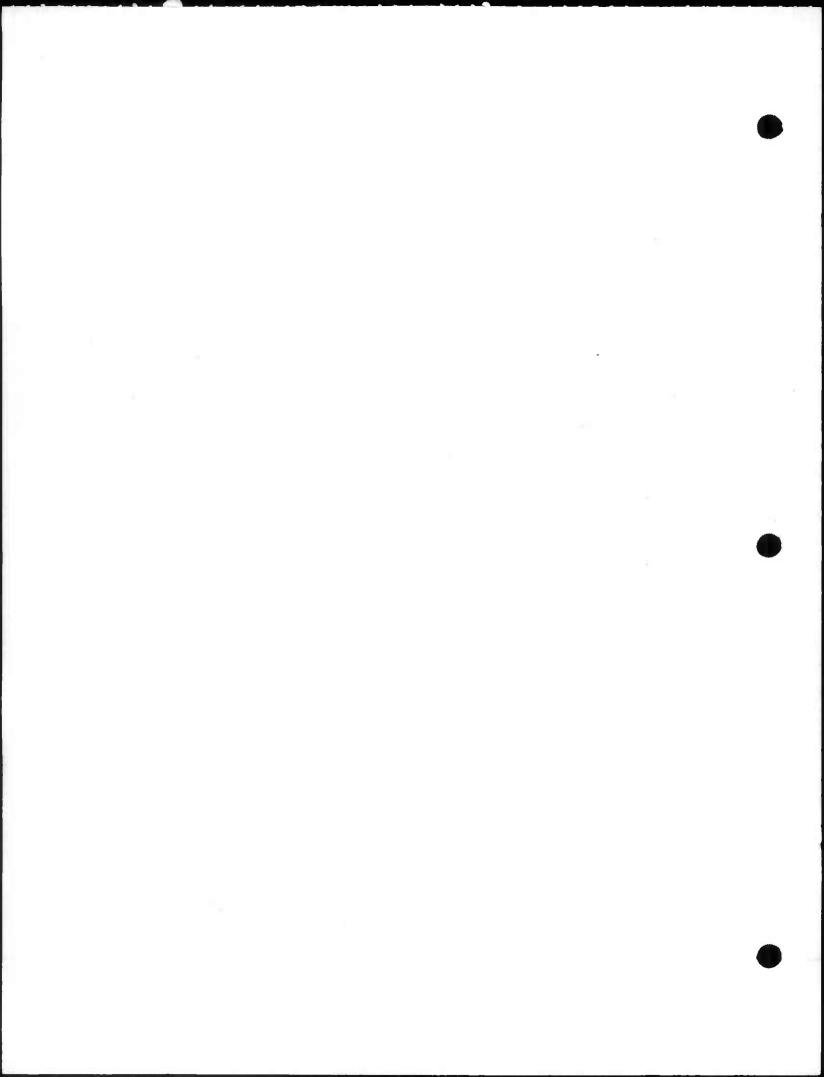
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mernal Hygiere prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | THEOROTTOM | | 01 | _,,,,,, | IOATE | | DEAL | 111 | R | EG. NO. | | | |
|---------------|--------------------------------------------------------------------------------------------------|----------------------------|---------------------|---------------------|------------------------------------------------------------|------------|---------------------|------------|------------------------------|-----------------------|-----------------------------------------|----------------------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, List) 2. DATE OF DEATH MONTH DAY YEAR 15:00 P | | | | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le: | na bilinda ni | | | | | | | | 15:00 P m | |
| | 213-07-9748 | 1 SM 2 - F | 79 | YRS. | IF UNDER | DAYS | HOURS | MIN. | (Month, De) | y. Year) | | Country | |
| | 9a. FACILITY NAME (If not Institution, give street and number) | | | | 9h CITY | TOWN | OR LOCATIO | ON OF DE | April | 3, _ | | Mar | |
| DIRECTOR | Church Hospital | , | | | | | ore C | | | | A | I/A | ain |
| | RESIDENCE OF DECEDENT | | | | | | | | | | 1 | V A | |
| 1 | 10e. STATE 10b. COUNT | | | | Y, TOWN | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | | /A | | Bal | Ltimo | | | | | | | | 1 X YES 2 ☐ NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | - 1 | . ZIP CODE | | | | | | HAT COUNTRY? |
| N. | 4530 Hazelwood A | 7 | | | | _ | 21206 | | | | | 5.A. | |
| | 1 Never Married 2 Married | FORCES? | T EVER IN U.S. AF | NO | | If yes, sp | ecify Cuba | n, Maxican | C ORIGIN? (Sp., Puerto Rican | pecify Yea , etc.) | or No- | | - American Indian, While, atc. |
| ВУ | 3 Wildowed 4 Divorced | IF YES, GIVE Y | MAR OR DATES | | | 1 U YES | 2 (XNO | Specify: | | | | White | ė |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad | JCATION e completed) | | CEDENT'S | | | ON ast of workin | - | | | INESS/INC | | |
| 91 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Do NOT u | se retired.) | during mo | ist or worten | v | | | nufa | actur. | ing |
| MP | 12th Grade | | IVII | llwri | Lgnt | | | | Comp | any | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | l _ | | NE (First, Middle | , Maiden | | | |
| BE | Thomas Unkn | own | | arone | | | Ros | _ | Lec | | | acche: | ri |
| 2 | Dorothy Madaline | Damono | | | | | | | oute Number, C | | | | 3 01006 |
| | 20s. METHOD OF DISPOSITION | Datone | 20b. PLACE | | | | | enue, | Balti | | | City or Tow | nd 21206 |
| | 1 Burlel 2 Cremetion 3 Rer | noval from State | Druid | Rido | ther place) | mete | erv | 9/8 | 1 | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENSIEE | 11. | | 22. NAME AND ADDRESS OF FACILITY | | | | | | aryrana | | |
| | *Kalthers M. M h. | | | | John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland | | | | | | | | |
| \dashv | 23. PART 1. Enter the disesses, or | complications the | t caused the de | ath. Do r | 104 | 1 CL: | sera1 | r Ko | ad, Ba | iltin | mre, | Mar | yLand 21206 |
| | shock, or heert fellure. | List only ons cer | ise on each line | | or orner | 1110 | ue or eyr | rig, aucti | aa cardiac | oi reapii | atory ar | rwat, | interval Between |
| | IMMEDIATE CAUSE (Final disease or condition DOLTE MYOC. | | | | LARDIAL INFARCTION | | | | | Onset and Death | | | |
| | resulting in death) | | (OR AS A CONSE | | | 1101 | | 1.07 | | | | | I VHY |
| Z | Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): | | | | | | | | 19 DAYS | | | | |
| 5 | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | | | |
| 2 | CAUSE (Disease or injury | 1 F | | HUR | E | | | | | | 19 DAYS | | |
| Ē | that initisted events reaulting in death) LAST | | PHYSE | | | | | | | | YEARS | | |
| CERTIFICATION | | | | | | | | | | | | | TOPR 3 |
| A | PART II. Other algnificent condition | | desth but not i | resulting | in the un | derlying | cause g | iven in P | Part I. 24s. | WAS AN | | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDICAL | HISTORY OF C | AN CERS | | | | | | _ 10 | _ 1 - YES 2 NO | | | COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | | | | _ | | | | 1 YES 2 NO |
| ä | DID TOBACCO USE CONT | RIBUTE TO CA | | | | | UNC | ERTAIN | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | |
| ₹ | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 26s. DATE OF | | DOA 28b, TIM | | | | | Other (Spe | | | | |
| = | 1 Natural 5 Pending | (Month, E | | | IURY | | RK? | _ | 28d. DEŞCRIB | E HOW IN | JURY OC | CURED | |
| B | 2 Accident Investigation 3 Suicide & Could not be | 26s. PLACE C | F INJURY — At ho | me, farm, s | street, fact | | | - | 281, LOCATION | N (Street a | nd Number | or Rumi Bo | uda Number |
| COMPLETED | 4 Homicide 6 Could not be detarmined | building, | etc. (Specify) | | | | | | City or Tox | vn, State) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Q. Filarer Fila | , and training, |
| Ä | 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | ICIAN: To the best of | my knowledge, da | ath occum | ed at the t | Ime date | and place | and due to | O the course(s) | and man | nor on etal | lad | |
| M I | one) 2 MEDICAL EXAMIN | | | | | | | | | | | | and manner as stated. |
| Ш С | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | | | NSE NUME | | 1 | | | Month, Day, Year) |
| 0 | stuckey Valy | own . | MD. | | | | DA | LEE | 25 | | • | 91 | 15/05 |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | O COMPLETED CAU | SE OF DEATH (ITE | М 27) (Туре, | Print) [| r. N | licke | V 1/2 | 105000 | | | | |
| | 30. NAME AND ADDRESS OF PERSON WILL CHURCH HOSPI | TAL | 100 N B | ROAL | WA | 4 | BA | ITM | -yasev 10R6 | ,MI |) ·Z | .123 | 1 |
| | 31, DATE FILED (MORRI, Day, 1881) | 32. HEGISTHA | H'S SIGNATURE | | | | | | , | | | | |
| | SEP1 1 1995 A | illy diswales | rhadell | | | | | | | | | | |





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DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

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29a. CERTIFIER

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DIRECTOR: hours after the litem 28 is

TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2

| | es 1, 2, 3 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 death with the State Dest. of Health and Mental Hotelep orlor to burial, cremation, or removal | |
| cian. | I-transit p | |
| ing physi | the buria | |
| or attend | use as | |
| hospital | ached for | . 69 |
| 1 by the | d be det | d at on |
| e retained | 5 shoul | notifie |
| 6 may b | ctor, page | nust be |
| ith. Page | neral dire | miner r |
| after dea | by the fur | Ical exa |
| 24 hours | filled in | he med |
| d within | ompletely cremat | event, 1 |
| NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physi | After this certificate has been signed by the attending physician and completely filled in by the fur death with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal | s marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| rtificate b | ig physici | ther tra |
| death ce | e attendir | ury, or o |
| that the | th and M | any in |
| requires | been sign | shows |
| : The law | tate Dept | tem 23 |
| YSICIAN | s certific th the S | d, or i |
| DING PH | After thi | s marke |
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95 27338 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH September 1995 6:30 P Evelyn D. **Echols** 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yra. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTNPLACE (State or Foreign Country) 7. DATE OF BIRTN (Month, Day, Year) Feb 25, 1 MONTHS DAYS HOURS 216-44-9721 1 M 2 TF 86 Washington DC 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Maryland General Hospiatl Baltimore n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland n/a Baltimore 1 TYES 2 NO 10a. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 2315 Pennyroyal Terrace 21209 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Ri 1 YES 2 X NQ Specify: 1 Never Married 2 X Married BY Specify 3 Widowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION
filiam kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) College Printer's Assistant U.S. Bureau Engrave & Print 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) James Barbour BE Julia Hansbouch 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 David Echols, Jr. 2315 Pennyroyal Terrace Baltimore, Maryland 21209 sept 9 20a, METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 ... 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State commetery, crematory or other place)
National Memorial Park ☐ Donation 6 ☐ Other (Specify) Laurel, Maryland 21. SIGNATURE OF THERE L SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway 21216 Baltimore, Maryland I. Inter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition unknown resulting in death) Aortic Aneurysm DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST

PART il. Other significent conditions

| | DUE TO (UN AS A CONSEQUENCE OF): | | | | | | | |
|----|---------------------------------------------------------------------------|----|--|--|--|--|--|--|
| | | | | | | | | |
| CC | ributing to death but not resulting in the underlying cause given in Part | i. | | | | | | |

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 X NO OF DEATH? 1 YES 2 NO

▶ 9-5-95

| DID TOBACCO USE CONT | YES 🗌 | NO 🗆 | UNCERTAIN [| | | | | |
|--------------------------------------------------------|-----------------------------------------------|--------------|-------------------|---------------|--|--|--|--|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| | HOSPITAL: 1 1 Inpetient 2 ER/Outpatient 3 DOA | OTHE 4 Nu | FI: rsing Nome | 5 Residence 6 | | | | |

27. MANNER OF DEATH 26s. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED

1 X Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 3 Suicide 6 Could not be 4 Homicide

| 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| | |

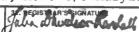
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| 29b | . SIGNATURE | AND TITLE OF CERTIFIER | 11 | | 29c. LICENSE NUMBER | 29d. DATE SIGNEO (Month, Day, Yea | r) | |
|-------------------------------|-------------|------------------------|----|--|---------------------|----------------------------------------------|-----|--|
| | one) | | | | | elecs, and due to the cause(s) and manner as | 1 8 | |
| 29a. CERTIFIER (Check only | | | | | | | | |

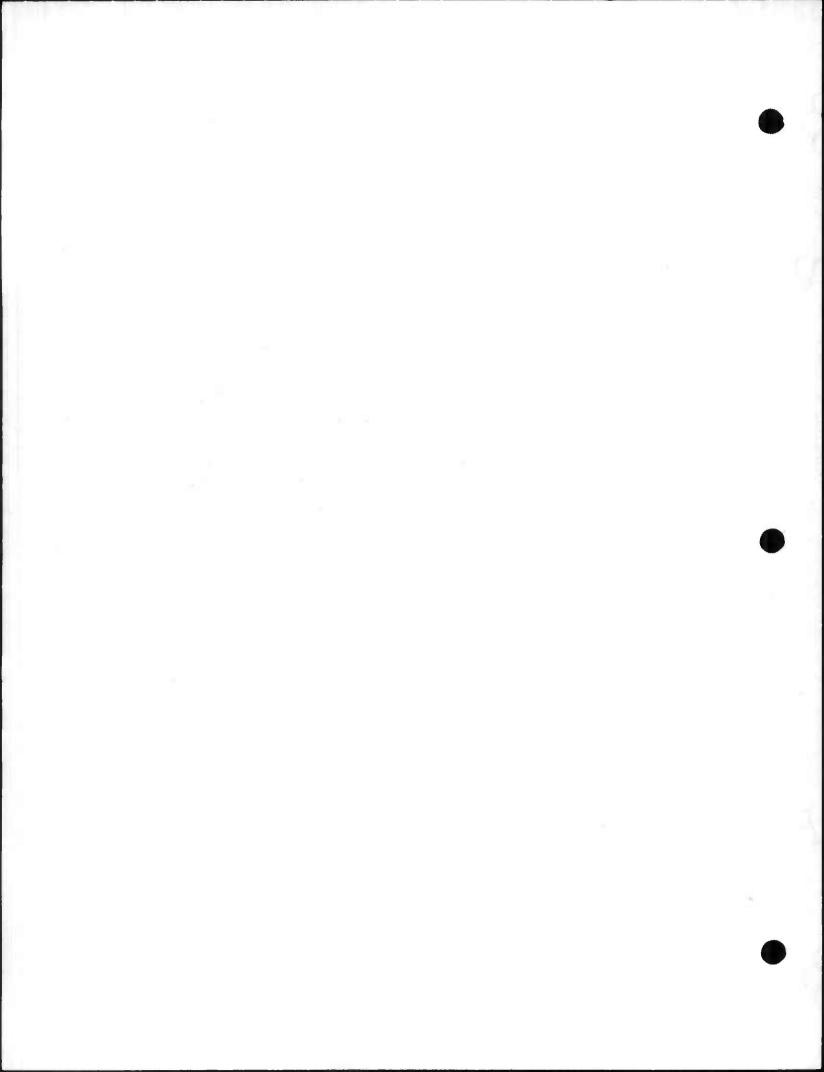
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.R. Zinelhadid, M.D. c/o Maryland General Hospital

31. DATE FILES (MODIF) 1



an stated.



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last

R

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

5. SEY 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 06 24-00 JUNE per as the burial-transit permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATN HAVEN BY FUNERAL DIRECTOR rsing Home atonsvi RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION Marylimo Baltimore 10s. STREET AND NUMBER 101. ZIP CODE ek GN 22 5+ 2 122 open of a mining physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HOO IF YES, GIVE WAR OR DATES WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
 If yes, specify Cuban, Mexican, Puerto Rican, etc.)
 UES 2 Specify: AND 21215-0020 ver Married 2 Married 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest Elementary/Secondary (0-12) EtICIAN LLLOWN be delac 17. FATHER'S NAME (Flost 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 BALTIMORE, MARYL retained by Ħ a 1 BE page 5 should hotified 19a. INFORMANT'S NAME (Type/Print) 2 ours after death. Page 6 may be 2 MEMORIAL POLES 20a. METHOD OF DISPOSITION

1 Burlat 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of must by the funeral director, removal. Donation 6 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY 3240 CHATMAN Tarris MBM medicai filled in by t 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart/fallure. List only one cause on each line. IMMEDIATE CAUSE (Final cremation, the disease or condition_ 4MPHOMA ICMANT completely resulting in death) HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event. DUE TO (OR AS A CONSEQUENCE OF): burial, other traumatic CERTIFICATION pur Sequentially list conditions, attending physician a DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 DIRECTOR: After this certificate has been signed by the atten hours after death with the State Dept. of Health and Merital I Item 28 is marked, or item 23 shows any injury, o PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) OTHER 1 YES 3 NO 1 | Inpetiant 2 | ER/Outpetient 3 | DOA 6 Other (Specify) 27. MANNEB-OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 20b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE FUNERAL D be filed within 72 ho IMPORTANT, If IN 2 MEDICAL EXAMINER: On the basis of examin red at the time, date end place, and due to the ceuse(a) and manner as stated. 290 SIGNATURE AND TITLE OF CERTIFIER BE 품 285 PINCOLL 2 WND COMPLETED CAUSE OF DEATN (ITEM 27) (Type. TASNEEM ARK HANI 7220 1 1995 32. REGISTRAR'S GIGHATURE

CERTIFICATE OF DEATH

4491151

95 27339 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 2. DATE OF DEATH 3. TIME OF DEATH 11:25P 8. BIRTHPLACE (St te or Foreig 1908 Virginia 9c. COUNTY OF DEATH Itimore 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Black 16b. KIND OF BUSINESS/INDUSTRY DAUIS 29 211 290/ LOCATION BUTUS REIJ BALLING, MAZIS Approximata Interval Batween Onset and Death 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2, NO 1 YES 2 1-110

21208

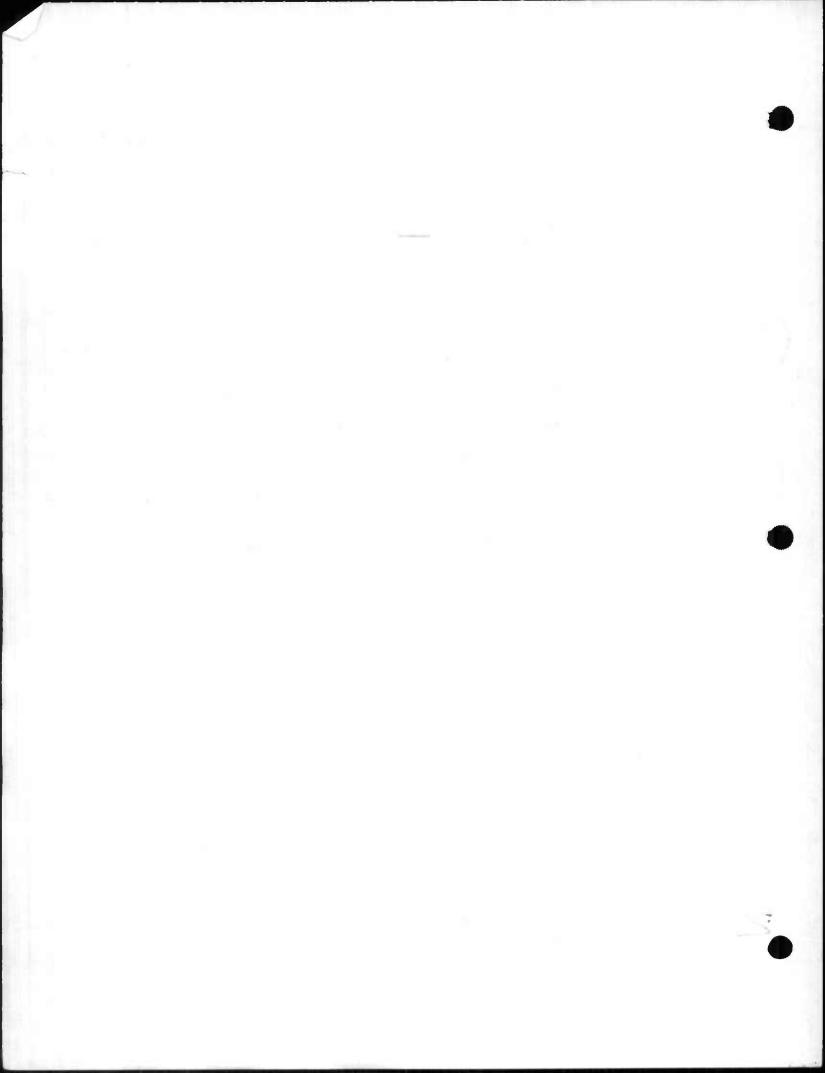
29d. DATE SIGNED (Month, Day, Year)

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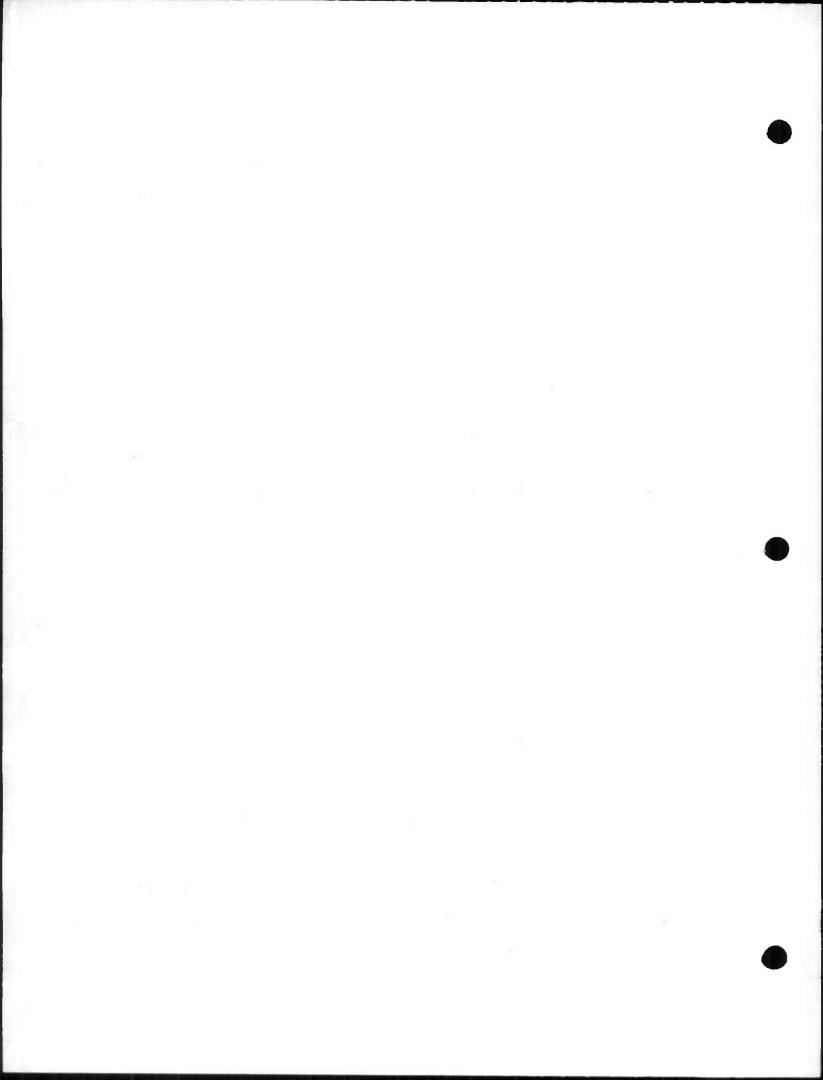
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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|---------------------------|
| FOR STATE REGISTRAR |
| 1. DECEDENT'S NA |
| THOMA: |
| 4. SOCIAL SECURIT |
| 213-68 |
| 90. FACILITY NAME |
| HARFOR RESIDENCE C |
| Marylar |
| 10e. STREET AND P |
| 184 N. |
| 11. MARITAL STATU |
| 1 Never Married |
| 3 Widowed 4 |
| (S) |
| Elementary/Sec |
| 12 |
| 17, FATHER'S NAME |
| Charle |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1. DECEDENT'S NAME (First | Middle, Last) | | | | | | | | | | 2. DAT | E OF DEA | тн | | | 3. TIME OF DEATH | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------|------------|---------------------|-------------|------------|-----------|----------|---------|----------------|----------|--------------|-------------|-----------|-------------------|------------------------------------------------------|------|
| THOMAS | | | IARL | | | | | ZIE | | | | EMBE | | 7, | 1995 | | |
| 4. SOCIAL SECURITY NUME | | 5, SEX | | in yrs. lesi 3 9 | t birthday) | MONTHS | DAY: | | NDER 2 | 4 HRS. MIN. | (Mor | oth, Day, Ye | ear) | . = . | Countr | | n |
| 213-68-94 | | | | 9 | YRS. | | | | | | | e 5 | , 19 | | | yland | |
| 9e. FACILITY NAME (If not in | | | | | | 100 | | N OR LO | | | | | | | INTY OF D | | |
| HARFORD M | EMORI | AL HOS | PITA | L | | I | HAV | RE | DE | GF | RACE | <u> </u> | | HA | ARFC | RD | |
| 10e. STATE | 10b. COUNTY | Υ | | | 10c. CIT | Y, TOWN | OR LO | CATION | | | | | | | | 10d. INSIDE CITY LIMITS? | |
| Maryland | Cec | i1 | | | N | ort | h | Eas | t | | | | | | _ | 1 TYES 2 1 NO |) |
| 10e. STREET AND NUMBER | | | | | | | | 10f. ZIP | | | | | | | | VHAT COUNTRY? | |
| 184 N. Ma | ain S | treet, | Ext | • | | | | 2 | 19 | 01 | | | | Ţ | JSA | | |
| 11. MARITAL STATUS | | 12. WAS OECEDER | T EVER IN | U.S. AR | MED (O | 13 | | | | | | IN? (Speci | | or No | 14. RACI Black | E — American Indian, k, White, etc. | |
| 1 Never Married 2 3 Widowed 4 X Divo | | 1975 | MAR OR DA | ATES | | | | YES 2X | | | | , | , | | Spec | "Y".White | |
| | EDENT'S EDU y highest grade | | | (Gi | CEDENT'S | work done | e during | | vorking | , | 16 | b. KIND O | F BUS | INESS/IN | DUSTRY | | |
| Elementary/Secondary (|)-t2) | College (1-4 or 5 | +) | | Do NOT u | | | | | | | | | | | | |
| 12 | | | | Fac | ctor | уи | lor | - | | | | Wi | | | | | |
| 17, FATHER'S NAME (First, M | | ogios T | _ | | | | | | | | | Middle, M | felden S | Sumame) | | | |
| Charles | | azier J | . 1 | - | | | | | - | | | ood | | | | | |
| Samuel F | | r | | | | | | | | | | nber, City | | , | , | Md 2190 | 1 |
| 20e, METHOD OF DISPOSIT | on 3 🗆 Rem | ioval from State | | | AND DATE | | | | | | 1 | | | | - City or To | le, Md. | |
| 4 Donation 6 Other | | CENSEE | _ 1 | ne ci | 0 0 | | | E AND AD | | S OF FA | | 11 | Cai | COILS | PATT | ie, Mu. | |
| antho | nyl | olt (| ori | nel | ly | | Co | nne. | 11 | y F | une | | | | of 21 | Dundalk 222 | |
| iMMEDIATE CAUSE (Fit disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY | clons, ediete | a. DUE TO | | CONSE | T, | | rie | es | | | | | | | | Interval Bett Onset and E | |
| CAUSE (Disease or Injusted initieted events resulting in death) LAS | | d. | OR AS | CONSE | OUENCE (| DF): | | | | | | | | | | | |
| PART il. Other algnific | ent condition | ns contributing to | deeth b | out not i | resuiting | in the | underi | ying car | use g | iven in | Part i. | | | AUTOPSY | 246 | WERE AUTOPSY FIND | |
| | | | | | | | | | | | | | ERFOR | | | AWAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? | USE |
| DID TOBACCO L | ISE CONT | RIBUTE TO CA | AUSE C | F DEA | TH Y | ES 🗆 | NO | D L | INCI | ERTAII | N D | | | | | | |
| 25. WAS CASE REFERRED | | | | | E OF DEA | | | | | | | 1 | | | | | |
| EXAMINER? | | HOSPITAL: | K ER/Out | patient 3 | □ DOA | OTH | | Home 5 | □ Res | sidence | 8 🗆 01 | her (Specil | fv) | | | | |
| 27. MANNER OF DEATH | | 28e. DATE 0 | F INJURY | | 28b. Til | WE OF | - | INJURY | _ | | _ | ESCRIBE | | NJURY O | CCURED | | |
| | Pending Investigation | Gronin, | 7 - 4 | 5 | | SOM | 1 | WORK? | 2 9 | NO | Pe | des | ma | ~ 5, | truci | < by aus | 10 |
| 2 Accident 3 Suicide 6 4 Homicide | Could not be determined | 28e. PLACE building | , atc (Spe | - At ho | | atreet, fo | ectory, o | office | | | 201. L.C | | Street e | nd Numbi | er or Rural | Route Number, | |
| 29e. CERTIFIER | TIFYING PHYS | SICIAN: To the best of | _ | | - | red at the | time | data and | niace | and due | - | | nd men | mer ee ee | ated. | | |
| (Critical Orliny | | | | | | | | | | | | | | | | e) end manner es stat | ied. |
| 29b. SIGNATURE AND TIFE | E OF GENTIFIE | 190 | OZ. | _ | | | | | - | NSE NU | | | E E | | | (Month, Day, Year) | |
| 30. NAME AND ADDRESS C | F PERSON WI | HO COMPLETED CA | USE OF DE | EATH (ITE | M 27) (Typ | e, Print) | | | | .М. | C. | 5 | ΕP | T F'M | BER | 8. 1995 | |
| Dovid | RF | owler | | 111 | | | Str | eet | | Ba] | tir | nore | | Mar | ylar | d 21201 | |
| SEP11199 | | 32. REGISTE | AR'S SIGN | NATURE | | | | | | | | | | | | | |

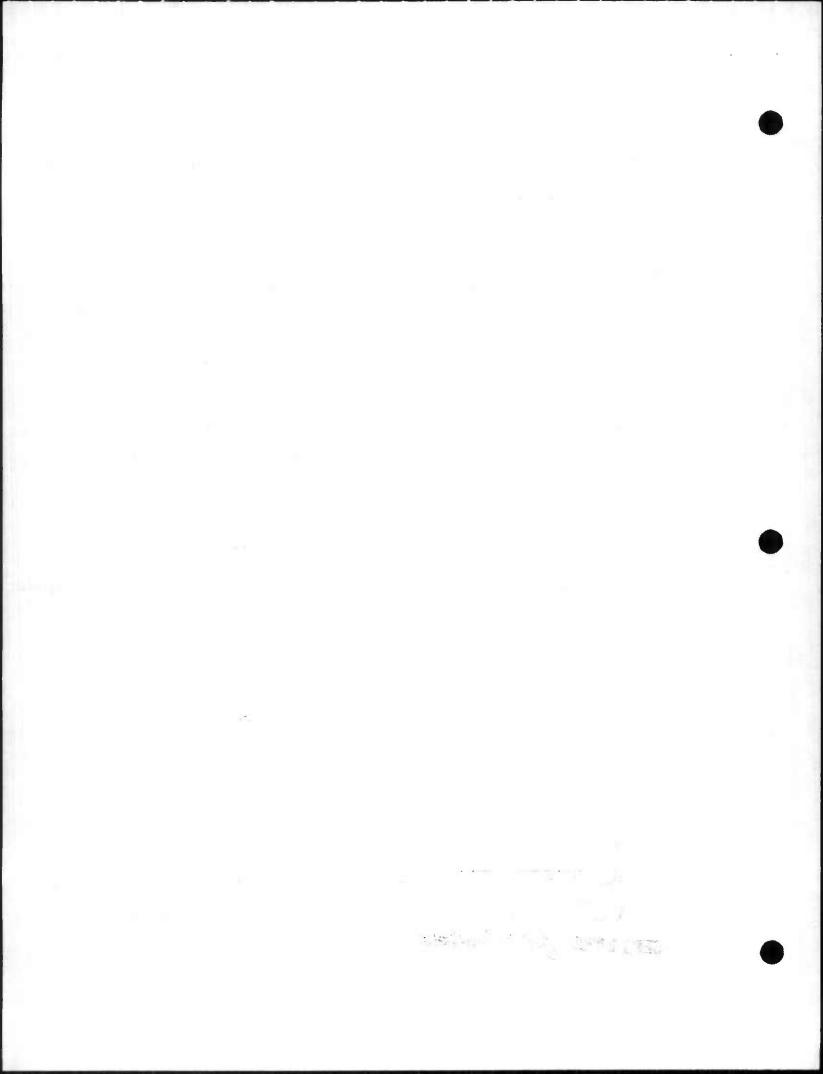


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DIVISION OF VITAL RECORDS, P.O. BO)

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | AL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDIN | TO THE FUNERAL DIRECTOR: After this of | be filed within 72 hours after death with th | IMPORTANT: If item 28 is marked, |

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALTH AND | MENTAL HYGIEN | _ | | | | | | |
|------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------|--------------------------------------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | |
| | MELL | 2,2 | | Flies | MONTH DA | × 2 | 7:10 0 M | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. last birthday) | F UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign | | | | | |
| | 217-36-9942 96. FACILITY NAME (If not institution, give str | | 55 YRS. | ONTHS DAYS HOURS MIN. | | | Washington, DC | | | | | |
| DIRECTOR | 13214 Dauphine Str | | | Silver Spring | | | tgomery | | | | | |
| EC | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATION | | | 10d. INSIDE CITY | | | | | |
| | Maryland Mon | ntgomery | S | Liver Spring | | | LIMITS? | | | | | |
| FUNERAL | | | | | | | N OF WHAT COUNTRY? | | | | | |
| Z | 13214 Dauphine Str | 12. WAS DECEDENT EVER IN | III ADMED | 20906 | | U.S | | | | | | |
| | 1 Never Married 2 Merried | FORCES? 1 YES | 2 XNO | 13. WAS DECENDENT OF HISP If yes, specify Cuban, Mexi- | can, Puerto Rican, etc.) | or No- 14 | I. RACE — American Indian, Black, White, etc. | | | | | |
| B⊀ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 TES ZXNO Spec | elfy: | | Specify: White | | | | | |
| | 15. DECEDENT'S EDUC | ATION | 16a. DECEDENT'S US | BUAL OCCUPATION | 16b, KIND OF BUS | I SINESS/INDUS | | | | | | |
| <u> </u> | (Specify only highest grade of Elementary/Secondary (0-12) | completed) College (1-4 or 5 +) | (Give kind of wor | k done during most of working retired.) | Long & | | | | | | | |
| 립 | | Years | Associate | Broker | Real Es | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | Tears | ASSOCIAL | | IAME (First, Middle, Meiden | | | | | | | |
| | Irving Fliss | | | Shir | ley Sherman | , | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street end Number or Rura | | n State Zin C | ordel | | | | | |
| 임 | Ronald Fliss | | | vin Hill Lane, | | | | | | | | |
| | 20e METHOD OF DISPOSITION AB Buriel 2 Cremetion 3 Remo | 206 | | | | | | | | | | |
| | 4 □ Donation 5 □ Other (Specify) | | etery, crematory or othe | pisposition (Name of 9/08) on Cemetery | /1995 | elnhi | Maryland | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | MIL LEDAI | 22, NAME AND ADDRESS OF I | ACILITY | | | | | | | |
| | Donald (| Stotel | myer | STEIN HEBREW 232 CARROLL | MEMORIAL F | UNERAL HTNGTC | HOME, INC. | | | | | |
| | 23. PART I. Enter the disessea, or co | | | enter the mode of dying, au | ch as cerdiac or reapi | ratory arres | t, Approximata | | | | | |
| | ahock, or heart failure. L | | | 01 | | | interval Between Onset and Death | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF): | | 70.6 | - | . | | | | | |
| CERTIFICATION | Sequentially list conditions, b. | DUE TO (OR AS A | CONSEQUENCE OF): | | 7 Care | | 2 Leany | | | | | |
| F | if any, leading to immediate cause. Enter UNDERLYING | 540 TO (011 NO X | CONSECUENCE OF). | | | | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | | |
| 8 | | • | | | | | | | | | | |
| AL | PART II. Other algolificent conditions | contributing to death b | ut not resulting in | the underlying ceuse given i | Part I. 24s. WAS AN. | | 24b. WERE AUTOPSY FINDINGS | | | | | |
| PHYSICIAN: MEDIC | | | | | 1 TES 2 | meo i | COMPLETION OF CAUSE OF DEATH? | | | | | |
| | | | | | | | 1 TYES 2 NO | | | | | |
| ž | DID TOBACCO USE CONTR | IBUTE TO CAUSE O | F DEATH YES | ☐ NO ☐ UNCERTA | IN 🗹 | | | | | | | |
| N S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | | | | | |
| Sic | 2 | HOSPITAL: 1 Inpatient 2 ER/Outp | | THER: Nursing Home 5 Residence | 6 Other (Specify) | | | | | | | |
| ξ | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| DF 28c. INJURY AT | 28d. DESCRIBE HOW IN | JURY OCCUP | RED | | | | | |
| BY | Netural 5 Pending Accident Investigation | (MONNY, Day, 10ar) | in son | WORK? M 1 YES 2 NO | | | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | - At home, ferm, stre | et, factory, office | 261, LOCATION (Street a | nd Number or | Rural Route Number, | | | | | |
| 밑 | 4 Homicide determined | bunung, stc. (Spec | ny) | | City or Town, Stete) | | | | | | | |
| COMPLETED | 29e. CERTIFIER 1 CERTIFYINO PHYSIC | IAN: To the best of my knowl | edge death occurred | nt the time, date end place, and du | o to the enuertal and man | | | | | | | |
| Ž | one) 2 MEDICAL EXAMINER | t: On the beele of examination | end/or investigation, | in my opinion, death occured at th | e time, date and place, and | d due to the c | teuse(s) and manner as stated | | | | | |
| | 29b. SIGNATURE AND JULLE OF CERTIFIER | | | | | | | | | | | |
| B | 20-0 | 30.00 | \ harmonia | 29c. LICENSE NO | CY (| 29d. DATE SI | IGNED (Month, Day, Year) | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | TH (ITEM 27) (Time Co | 7-0.8 | , 17 | >2 | BI 2 11 | | | | | |
| | | , [| | | 6 11 | Con | and me | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | 8 W. S & | -SIN | Acre | _ | | | | | |
| 1 | SEP1 1 1995 A | 1 Studente | J. H | | | | | | | | | |
| 1 | 7. | | A PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR | | | | _ | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | to bunal, cremation, or removal. | imatic event, the medical examiner must be notified at once. |
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| Ţ | t | em #1. | G-film? | 727 | per | F.H | 9/13 | /95 | P. | C | | | |
|---|---|--------------|---------|-------|-------|-----|--------|-------|-----|-------|----|--------|----------|
| 4 | | FOR STATE | | STATE | OF MA | | | | | | | MENTAL | HYGIENE |
| 1 | - | REGISTRAR | | | | (| CERTIF | ICATE | E 0 | F DEA | TH | | REG. NO. |

| HEGISTHAN | | <u> </u> | LATITIC | AIL OI | DEATH | AEG. NO. | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------|------------------|-------------------------|---------------------------------------------------------------------------------|-------------|--------------------------------------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Li Virginia | , | n G | reenst | reet. | | 2. DATE OF DEATH DAY Sept. 9 | 199 | year 3. TIME OF DEATH | | | |
| 4. SOCIAL SECURITY NUMBER | 5, SEX | 6. AGE (In vrs. la: | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTNPLACE (State or Foreign | | | |
| 215 09 5285 | 1 🗆 M 2 💢 F | 78 | YRS. | NTHS DAYS | HOURS MIN. | March 28, | | Maryland | | | |
| Se. FACILITY NAME (If not institution, g | ive street and number) | | 91 | b. CITY, TOWN | OR LOCATION OF DI | EATH | 9c. COUNT | Y OF DEATH | | | |
| BelforestNursing RESIDENCE OF DECEDENT 10s. STATE 10s. COL Maryland H | & Rehab. | Center | | For | est Hill | | Har: | ford | | | |
| 10a. STATE 10b. COL | INTY | | 10c. CITY, T | OWN OR LOC | ATION | | | 10d. INSIDE CITY | | | |
| | arford | | | | orest Hil | 1 | | 1 VES 2 XNO | | | |
| 100. STREET AND NUMBER | | | | 1 | or, ZIP CODE | | 10g. CITIZE | EN OF WHAT COUNTRY? | | | |
| 100. STREET AND NUMBER 1622 D Rebect 11. MARITAL STATUS 1 Never Merried 2 Merried | ca Ct. | | | | 21050 | | Un: | ited States | | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT | | | | | NIC ORIGIN? (Specify Yes | or No- 1 | 4. RACE — American Indien, Black, White, etc. | | | |
| 1 Never Merriad 2 Merriad 3XXWidowed 4 Divorced | I IF YES, GIVE WAR OR DATES | | | | | n, Puello Rican, atc.) y: | | Specify: White | | | |
| 15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last, | | 18e. Di | ECEDENT'S US | UAL OCCUPAT | TION nost of working | 16b, KIND OF BUS | SINESS/INDU | STRY | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5 + | | e. Do NOT use n | etired.) | | 1 | | | | | |
| 12 | | | Line | Operat | tor | | Factor | rv | | | |
| 17. FATHER'S NAME (First, Middle, Last, | | | | | | ME (First, Middle, Maiden | | - | | | |
| | oxwell | Branna | n | | Eliza | | | ohnson | | | |
| | OXWEIL | | | | | | | | | | |
| O I 190. INFOHMANT'S NAME (Type/Print) | | | | | | Route Number, City or Tow | | | | | |
| F Sally Eary | | | 214 E. | Main | Street, | New Freedo | m,PA | 17344 | | | |
| 20a. METHOD OF DISPOSITION | DATE OF THE PERSON | 20b. PLACE | AND DATE OF | DISPOSITION | Neme of | DATE 20c. LO | CATION — C | ty or Town, State | | | |
| 1 Buriei 2 X Cremation 3 1 4 Donation 8 0 Other (Specify) | Removal from State | Gree | n Moun | t Crer | natory 9/ | 12/95 B | altim | ore MD | | | |
| 21. SIGNATURE OF UNERAL SERVE | E LICENSUM | 01.00 | 11 110011 | 22. NAME | AND ADDRESS OF FA | CILITY | | | | | |
| Stol & | 190 | m | | | | D. Lohrman | | timore,MD 21286 | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| E | d | | | | | | | | | | |
| PART II. Other eignificent cond | PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICA | NL | 26. PLA | CE OF DEATH | (Check only on | e) | | | | | | |
| EXAMINER? | HOSPITAL: | EB/Outputient | 2 0004 | THER: | 4 D B | 0 - 0 - 0 - 1 | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATN | 28e. DATE OF | | 28b. T | and the same of | ome 5 Residence | 2ad. DESCRIBE NOW | IN HIRV OCC | IDED | | | |
| | (Month, D | | print. | EV. | WORK? | 286. DESCRIBE NOW | INJUNI OCC | SNED | | | |
| 3 Suicide a Could no | 28e. PLACE O building, | F INJURY — At h atc. (Specify) | nome, ferm, atro | eet, fectory, of | fice | 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stefe) | | | | | |
| (Criedit brilly | NYSICIAN: To the best of MINER: On the bests of e | | | | | | | d. ceuse(s) end manner es stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERT | Leil | | | | 29c. LICENSE NU | MBER 39 | ≥ Se | SIGNED (Month, Day, Year) Plember 11, 199 | | | |
| 30. NAME AND ADDRESS OF PERSON | - | | | - 1 | 1 | 1 | | | | | |
| LINDA F | TOG I LLG | SE OF DEATH (IT | EM 27) (Type, B |] 1 | 1000 | Lear 1 | elm | 1 MOZ 1011 | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

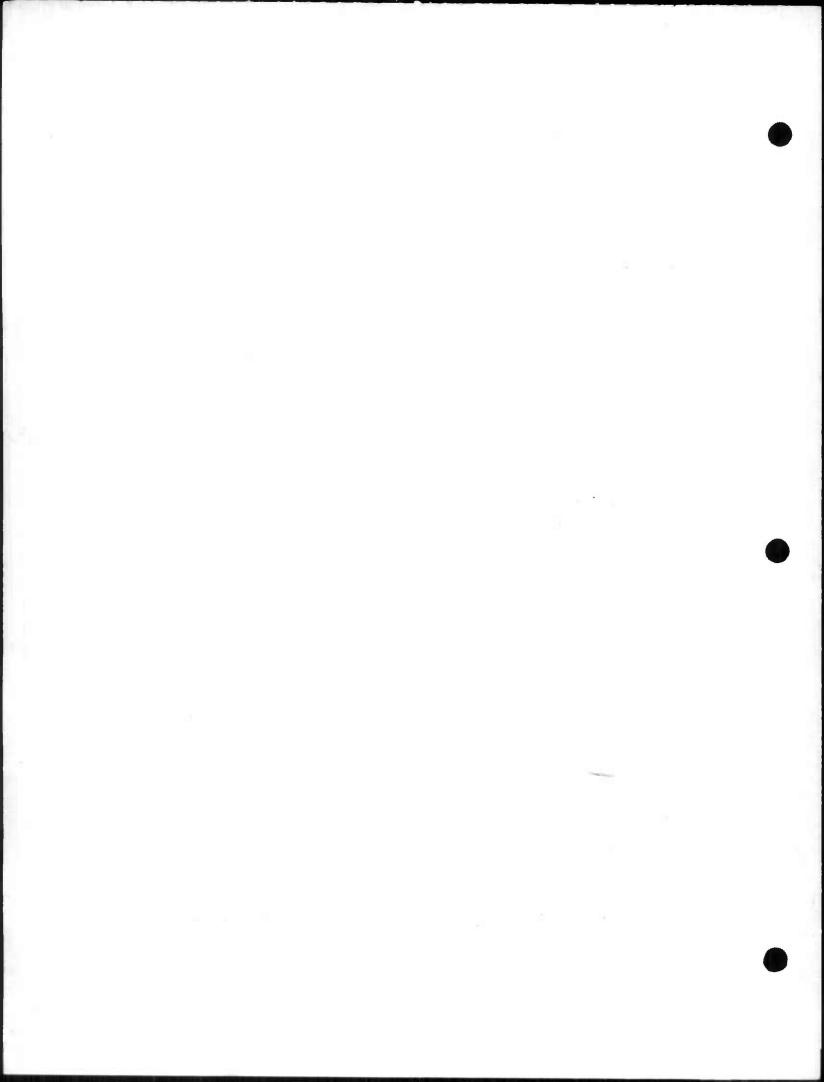
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

2/95 t.t

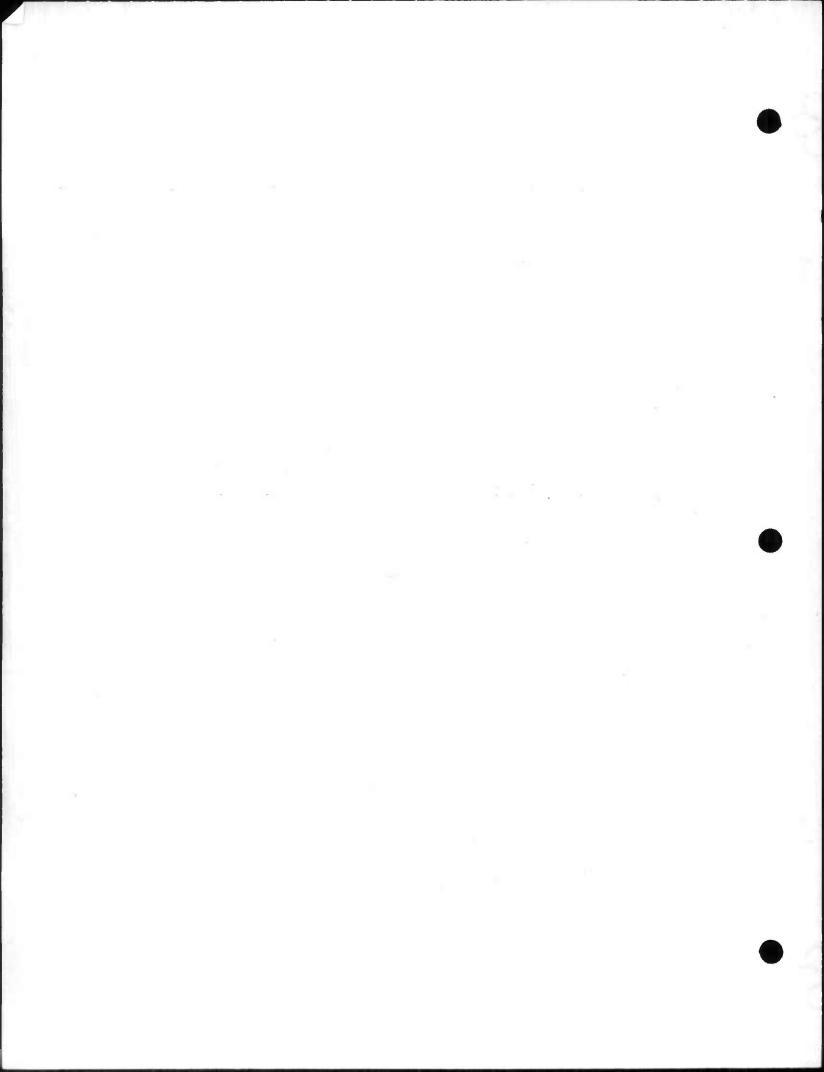
| | | ITEMS: | 23 | PART | Ι, | 27, | 28a-f | PER | MEO | FILM | G-728 | 10/ | 1 |
|---|------|---------------------------|---------|-------------|-------|--------|---------|--------|------------|---------------|----------|--------|---|
| 1 | ٠ | FOR STATE REGISTRAR | | | | STA | TE OF I | ARYL | | | RTMENT | | |
| | 1. D | ECEDENT'S NAM | NE (Fir | st, Middle, | Last) | | | | | | | | |
| ŀ | | LYDIA | 1 | | L. | | GA | RMA | N | | | | |
| | 4. S | OCIAL SECURIT | Y NUA | 18ER | | 5. SE) | (| 6. AGE | (In yrs. I | nst birthday, | IF UNDER | 1 YEAR | Į |
| | 4 | 212-30- | 366 | 36 | | 1 🗆 | M 2 X F | | 84 | YRS. | MONTHS | DAYS | |

| 1 - STATE REGISTRAR | | | | | ATE OF | | MENIA | REG. NO. | Ε | | |
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| 1. DECEDENT'S NAME (First, | Middle, Last) | | 921 | 111110 | 112 01 | DEMIN | | OF OEATN | | | OF DEATN |
| LYDIA | L. | GARMA | N | | | | SEP. | | 5,1995 | 08 | 29 A M |
| 4. SOCIAL SECURITY NUMBI | ER : | 5. SEX 6. AGE | (In yrs. last bi | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTN | 8. 1 | DIRTHPLACE (S | |
| 212-30-3666 | 5 | 1 🗆 M 2 💢 F | 84 | YRS. MON | THS DAYS | HOURS MIN. | JAN. | | | Maryla | nd |
| 9a. FACILITY NAME (If not ins | | | | | | R LOCATION OF DE | | | 9c. COUNTY | | |
| UNIVERSITY | | TTAL S.T. | . U | | RALLI | MORE CI | 1 1 | | | N/A | |
| 10a. STATE | 10b. COUNTY | | 1 | Oc. CITY, TO | WN OR LOCAT | TION | | | | | SIDE CITY |
| Md. | 8a1 | timore | | Cato | nsvill | .e | | | | | S 2 NO |
| 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | - | | 10g. CITIZEN | OF WHAT CO | UNTRY? |
| 719 Maiden | Choice | La., Apt. | BR 23 | 7 | | 21228 | | | U | SA | |
| 11, MARITAL STATUS | | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARME | D | | ENDENT OF NISPAI | | | or No — 14. | RACE - Amer Block, White, | rican Indian, etc. |
| 1 Never Merried 2 3 Y Widowed 4 Divor | | IF YES, GIVE WAR OR | DATES | | | 2 X NO Specif | | , , , , , , | | Specify: | hite |
| ^ | DENT'S EDUCA | TION | 16a DECE | DENT'S USL | AL OCCUPATION | ON | 166 | KIND OF BU | SINESS/INDUST | | 11200 |
| | highest grade of | | (Give | kind of work NOT use re | done during mo | ast of working | 100 | Tarib or bo | 011120071112001 | | |
| 12 | 12) | N/A | Н | omema | ker | | 0 | wn Hor | ne | | |
| 17. FATHER'S NAME (First, Mil | ddle, Last) | | | | | 18. MOTHER'S NA | ME (First, | Middle, Maiden | Sumame) | | - |
| George | W. Hob | bs | | | | Leador | a Ri | ng | | | |
| 19a. INFORMANT'S NAME (7) | | | | | | and Number or Rural | | | | | |
| Ernest T. | Greffe | en | 5 | 902 6 | race L | ee Ave., | Syk | _ | | | |
| 20a. METHOD OF DISPOSITI 1X Burlal 2 Crematio 4 Donation 6 Other | n 3 🗆 Remov | ral from Stata Co | MEACEAN | DATE OF D | ISPOSITION (No | orial Par | 9/ | | cation – chy | | - 3 |
| 21. SIONATURE OF FUNERAL | | | | WIIIG | 22. NAME A | ND ADDRESS OF FA | CILITY | | | | |
| 11 | 1100 | 0/2 | | / | | L. Kaufn | | | | | |
| 23. PART I. Enfor the di | 20000 01/0 | mplications that cause | ad the deat | Do not | | Main St. | | | | | pproximate |
| shock, or he | eart falluge. Li | ist only one cause on | each line. | BO HOL | oritor the inc | or dying, add | | J. 100 O. 100p | matory arrost | In | terval Batween |
| immediate cause (Fin disease or condition | al | MULTIPLE IN | HIDTES | | | | | | | | inser and Death |
| resulting in death) | a. | OUE TO (OR AS | | ENCE OF): | | | | | | | |
| | | | 4 | | | | | | | ļ | |
| Sequentially list conditi if any, leading to immed | | OUE TO (OR AS | A CONSEQUE | ENCE OF): | | | | | | | |
| CAUSE (Disease or Inju | | | | | | | | | | | |
| that initiated events | | | A CONSEQUI | | | | | | | | |
| resulting in death) LAS | ´ | DUE TO (OR AS | | ENCE OF): | | | | | | | |
| resulting in death) LAS | ´ | DUE TO (OR AS | | ENCE OF): | | | | | | | |
| PART II. Other significa | T d. | | | | he underlyln | g cause given in | Part I. | 24a. WAS AN | | | UTOPSY FINDINGS |
| | T d. | | | | he underlyln | g cause given in | Part I. | 24a. WAS AN PERFO | RMED? | COMPLI | ETION OF CAUSE |
| | T d. | | | | he Underlyln | g cause given in | Part I. | PERFO | RMED? | AVAILAE COMPLI OF DEA | ETION OF CAUSE |
| PART II. Other significa | nt conditions | | but not res | ulting in t | | | _ | PERFO | RMED? | AVAILAE COMPLI OF DEA | LE PRIOR TO ETION OF CAUSE TH? |
| DID TOBACCO U | nt conditions SE CONTR D MEDICAL | contributing to death | but not res | ulting in t | NO E | UNCERTAI | _ | PERFO | RMED? | AVAILAE COMPLI OF DEA | LE PRIOR TO ETION OF CAUSE TH? |
| PART II. Other significa | nt conditions SE CONTR | contributing to death | OF DEATH | ulting in t | NO E | UNCERTAI | N 🗆 | PERFO | RMED? | AVAILAE COMPLI OF DEA | LE PRIOR TO ETION OF CAUSE TH? |
| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XXYES 2 \(\) NO 27. MANNER OF DEATN | nt conditions SE CONTRI | Contributing to death IBUTE TO CAUSE HOSPITAL: 1 tnpettert 2X XFLOOT 28a. DATE OF INJUR (Month, Day, Year | OF DEATH- 26. PLACE | ulting in t | NO ECHECK only one) THER: Nursing Hor | UNCERTAI | 6 Oth | PERFOI 1 VES : or (Specify) SCRIBE NOW | RMED? 2 NO NO INJURY OCCUR | AMAILAE COMPLI OF DEA' | NLE PRIOR TO ETHON OF CAUSE TH? ES 2 NO |
| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XXYES 2 D NO 27. MANNER OF DEATN 1 Netural 5 | nt conditions SE CONTR | IBUTE TO CAUSE HOSPITAL: Inpetient 2X KR/00 28. DATE OF INJUR Month, Day, Year 9/5/95 | OF DEATH 28. PLACE | H YES DF DEATH (DOA 41 ROUNDER 6:30 A | NO E Check only one) THER: Nursing Hor F 28c. IN W 1 | UNCERTAI | 6 Otho | PERFOIL 1 YES: or (Specify) SCRIBE NOW | RMED? 2 \(\to \) NO INJURY OCCUR | AVAILAE COMPLIA OF DEA 1 VI | ILE PRIOR TO ETION OF CAUSE THY ES 2 NO |
| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATN 1 Natural 5 2 Accident 3 X Suicide 6 | SE CONTR | Contributing to death IBUTE TO CAUSE HOSPITAL: 1 tnpettert 2X XFLOOT 28a. DATE OF INJUR (Month, Day, Year | OF DEATH 28. PLACE utpetient 3 [y) RY — At homeocity) | H YES DF DEATH (1) DOA 41 28b. TIME 0 INJURY 6:30 A 3, tarm, street | NO E Check only one) THER: Nursing Hor F 28c. IN W 1 | UNCERTAI | 6 Othor | er (Specify) SCRIBE NOW CCT PREC | INJURY OCCUR IPITATE and Number or 7719 MAI | AMAILAR COMPLIA OF OEA 1 VI | ALCONY |
| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATN 1 Netural 5 2 Accident 3 XX Suicide 6 4 Homicide | SE CONTRID MEDICAL Pending Investigation | Contributing to death IBUTE TO CAUSE HOSPITAL: 1 Inpetient 2X X RVOX 26a. DATE OF INJUR (Month, Day, Year, 9/5/95 26e. PLACE OF INJU | OF DEATH 28. PLACE utpetient 3 [y) RY — At homeocity) | H YES DF DEATH (DOA 41 ROUNDER 6:30 A | NO E Check only one) THER: Nursing Hor F 28c. IN W 1 | UNCERTAI | 6 Othor | PERFOIL 1 VES : or (Specify) SCRIBE NOW CT PREC | INJURY OCCUR IPITATE and Number or 7719 MAI | AMAILAE COMPLIA OF DEA 1 VI | ALCONY |
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| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATN 1 Netural 5 2 Accident 3 XXSuicide 6 4 Homicide 29a. CERTIFIER (Check only | SE CONTR D MEDICAL Pending Investigation Could not be determined | Contributing to death IBUTE TO CAUSE HOSPITAL: 1 Impatient 2X X PLOO 26a. DATE OF INJU 6/5/95 26a. PLACE OF INJU building, etc. (Sy | OF DEATH 26. PLACE At patient 3 Y RY — At home | Ulting in t YES OF DEATH (DOA 4 200. TIME OF RIVER 6:30 A , tarm, street HOME | Check only one) THER: Nursing Hor F 28c. IN. W H 1 pt, tectory, office | UNCERTAI THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STAT | 6 Oth 28d. DE SUBJE 28f. CAT(CAT(| PERFOIL I EYES: OF (Specify) SCRIBE NOW CT PREC CATION (Street or Town, State DNSVILLE Use(e) end me | INJURY OCCUR INJURY OCCUR IPTATEL and Number or 719 MAIL before as stated, and due to the c | AMILAR COMPLIA OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA 1 VIII OF DEA | ALCONY The LANE 21228 The prince of stated. Day, Veer) |
| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATN 1 Netural 5 2 Accident 3 XX Suicide 6 Homicide 29a. CERTIFIER (Check only one) 2 X MEDI | SE CONTRIDE MEDICAL Pending Investigation Could not be determined IFYING PHYSIC ICAL EXAMINER | Contributing to death IBUTE TO CAUSE HOSPITAL: 1 Impetient 2X X FROOT 26a. DATE OF INJUIT (Month, Day, Year, 9/5/95 28e. PLACE OF INJUIT building, etc. (S) IAN: To the best of my knot; On the bests of examinate | OF DEATH 26. PLACE outpetternt 3 Ty RY — At homeocify) owiedga, death itton and/or inv | Ulting in t I YES OF DEATH (DOA 4 20b. Time o INJUR 6:30 A , tarm, street HOME | Check only one) THER: Nursing Hor F 28c. IN. W 1 pt, tectory, office t the time, det | UNCERTAI THE S Rasidence JURY AT ORK? YES 2 XX NO ca The and place, and du death occured at the | 6 Oth 28d. DE SUBJE 28f. CAT(CAT(| PERFOIL I EYES: OF (Specify) SCRIBE NOW CT PREC CATION (Street or Town, State DNSVILLE Use(e) end me | INJURY OCCUR INJURY OCCUR IPTATEL and Number or 719 MAIL before as stated, and due to the c | AMALAR COMPLIANT OF OEA 1 VI | ALCONY The LANE 21228 The prince of stated. Day, Veer) |
| DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? XYES 2 NO 27. MANNER OF DEATN 1 Netural 5 2 Accident 3 X Suicide 6 4 Homicide 298. CERTIFIER (Check only one) 2 X MEDI 29b. ERMIATURE AND TITLE | SE CONTRIDE MEDICAL Pending Investigation Could not be determined IFYING PHYSIC ICAL EXAMINER | COMPLETED CAUSE OF COMPLETED CAUSE OF INJURATION OF COMPLETED CAUSE OF INJURATION OF COMPLETED CAUSE OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF INSURATION OF | DEATH 26. PLACE 26. PLACE 27 27 27 28 29 20 20 20 20 20 20 20 20 20 20 20 20 20 | Ulting in t I YES OF DEATH (DOA 4 28b. Time 0 INJURY 6:30 A , tarm, street HOME 1 occurred a sestigation, i | NO E Check only one) THER: Nursing Hor F 28c. IN. H 1 pt, tactory, office the time, date n my opinion, | UNCERTAI THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STAT | N □ 28d. DE SUBJE 28f. Loc Chy CAT(e to the ce time, det | PERFOIL I VES: If (Specify) SCRIBE NOW CT PREC CATION (Street or Town, State DNSVILLE DUSCILLE DUS | INJURY OCCUR INJURY OCCUR IPITATE and Number or 2719 MAII before as stated. and due to the c 29d. DATE S SEP | AMAILAR COMPLIA OF DEA 1 VI FROM B Rural Route Nur DEN CHOI TO., MD. GONEO (Month. T. 6, 1 | ALCONY The control of cause the control of cause the control of cause the control of cause the control of cause the control of cause the control of cause the control of cause the control of cause the control of cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the caus |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPART | | | MENTA | L HYGIEN | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------|--------------------------|------------------------------------------------------------|-------------|--------------------------------|-------------------|---------------------------------------------------------------------------------------|----------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE | E OF DEATH | AY YI | 3. TIME OF DEATH | |
| | | MARK | DWAYNE | | OODEN | | | GUST 7 | 4,199 | 5 11:41 | PM. |
| Pin | | 234-44-35 | 1 № M 2 🗆 F 29 | YRS. | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | (Mon | OF BIRTH th, Day, Year) -13-65 | | BIRTHPLACE (State or Foreig Country) | ın |
| 3 should | Œ | 9a. FACILITY NAME (If not institution, give stre | | 1 | | OR LOCATION OF D | | | 9c. COUNTY | OF DEATH | |
| 1, 2, | DIRECTOR | JOHNS HOPKINS H | OSPITAL | | | MORE CI | .'I'Y | | | | |
| 020 physician. burial-transit permit. Pages 1, 2, | | Maryland 106. COUNTY | | | town on Local ltimore | | | | | tod. INSIDE CITY LIMITS? t X YES 2 NO | |
| in. ransit perr | VERAL | 1608 East 28th St | reet | | 101 | 21218 | | | U.S. | A. | |
| YLAND 21215-0 by the hospital or attending be detached for use as the at once. | BY FUNI | 1t. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U. FORCES? 1 YES | 2 NO | if yes, sp | CENDENT OF HISPA Hecity Cuben, Mexico 3 2 NO Special | an, Puerto | | or No 14. | RACE — American Indian, Black, White, etc. Specify: Black | |
| | PLETED | 15. DECEDENT'S EDUCA (Specify only highest grade oc Elementary/Secondary (0-12) | TiON 16 mpleted) 16 College (1-4 or 5+) | Give kind of wo life. Do NOT use | k done during mo | | 161 | b. KIND OF BUS | SINESS/INDUST | TRY | |
| | E COMPL | 17. FATHER'S NAME (First, Middle, Last) | 7. FATHER'S NAME (First, Middle, Last) | | | | | Middle, Maiden | Surname) | | |
| MAR be retained pe 5 should | | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DORESS (Street a | and Number or Rurel | Floute Nurr | ber, City or Tow | n, State, Zip Coo | je) | |
| AORE, ge 6 may be irectoir, page | | 20a. METHOD OF DISPOSITION 1 | State comete | ACE AND DATE OF ry, crematory or other | | ame of | OAT | E 20c. LO | CATION City | or Town, Stata | |
| BALTIMORE, nours after death. Page 6 may be d in by the funeral director, page or removal. medical examiner must be a medical examiner. | | 21. BIGHATURE OF PINERAL SERVICE LICENSEE Ronald Wade, Dir. 22. NAME AND ADDRESS OF FACE State Anatomy Rm. B026-Baltin | | | | | | | | | .eet |
| 760 ed within 24 hours ompletely filled in t il, cremation, or re- | | 23. PART I. Enter tha diseases, or conshock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) | MULTIPLE DUE TO TOR AS A CO | 1 IINe. | | | oh aa car | diac or reapi | raiory arrest, | Approximate interval Betwo Onset and De | |
| P.O. BOX 68 th certificate be executeding physician and if Hygiene prior to bur or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| AL RECORDS, F he law requires that the death has been signed by the atte o Dept. of Health and Mental in 23 shows any Injury, or | MEDICAL (| PART II. Other aignificant conditions | contributing to death but | to death but not resulting in the underlying cause given in | | | | | AUTOPSY IMED? | 24b. WERE AUTOPSY FINDIF AMAILABLE PRIOR TO COMPLETION DF CAUS OF DEATH? 1 XFES 2 NO | |
| | | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF I | DEATH YES | □ NO □ | UNCERTAI | N \square | | | · × · · · · · · · · · · · · · · · · · · | |
| ► F 8 8 5 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. | PLACE OF DEATH | (Check only one) | | | | | | = |
| . 0 0 5 | HYS | | 28e. DATE OF INJURY | int 3 DOA 4 | ☐ Nursing Hom | e 5 🗆 Residence | | | | | _ |
| NG PHYSIC frer this cer sath with the | 0 | 1 Natural 5 Pending | (Month, Day, Year) | 296. TIME (INJUI 2332 | Y WO | RK? | 28d. DE | SCRIBE HOW II | OLLAT | žD. | |
| |) BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJURY | | 1 | | 281. LOC | ATION (Street a | and Number or F | Rural Route Number, | \dashv |
| DIVISION DE ATTENE DIRECTOR: DONECTOR: Hours after Item 28 Is | COMPLETED | 4 Homicide determined | building, atc. (Specify) | TREET | | | S Oc | MONTE | GRO AU | B. BALTIMERS | M |
| DIV L DIREC 2 hours | 2 | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA | IN: To the best of my knowledg | je, death occurred | at the time, date | and place, and due | to the car | | | | |
| SSPITA INERA thin 73 | Ŏ. | | On the basis of examination an | | | | | | | use(s) and manner as stated | d. |
| DIV TO THE HOSPITAL DR A TO THE FUNERAL DIREC DE filed within 72 hours IMPORTANT: If Item | TO BE | 299 SIGNATURE AND TITLE OF CHITTERER | Soll A | Ĭ. | | O . C . M | | | | GUST 5,199 | 5 |
| | | MARIO + GALK | JRMOU | lll Per | | eet, Ba | lti | more, | Mary. | land 21201 | |
| | | 31. DATE FILED (Month, Day, Year) SEP11 1995 | Julia d'auction | Rardall | | | | | | | |



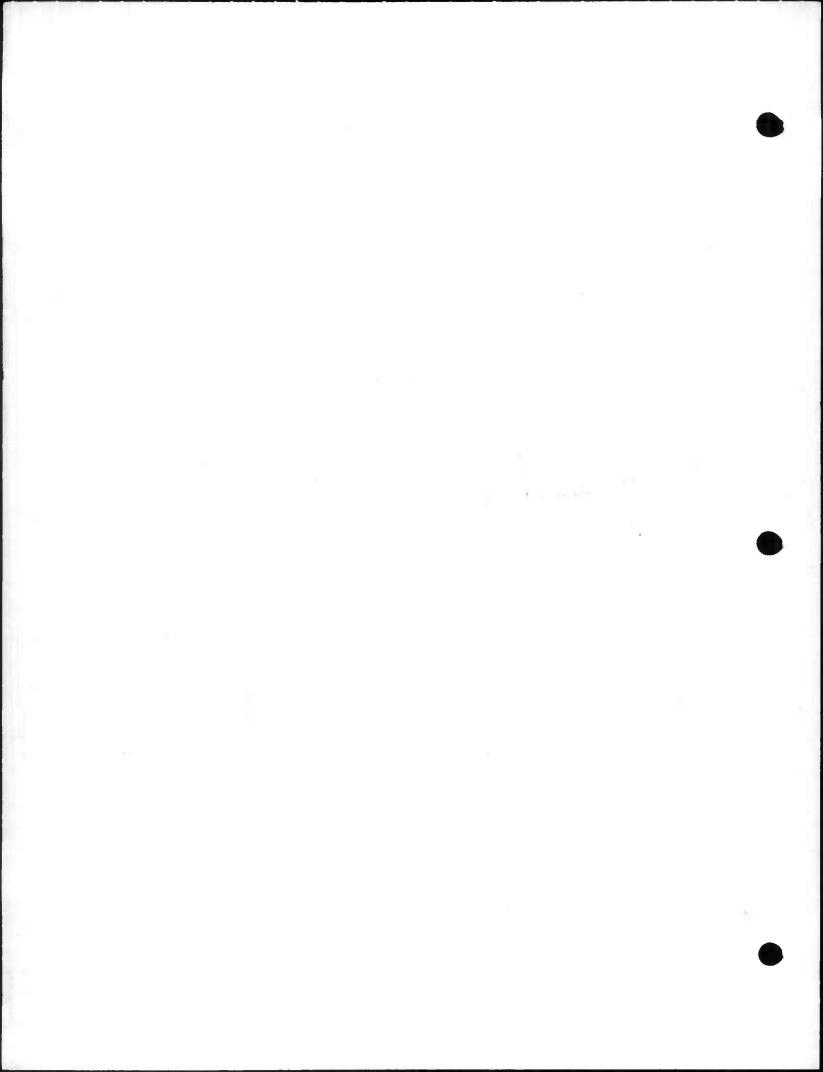
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| BALTIMORE, MARYLAND 212 | hours after death. Page 6 may be retained by the hospital or a | led in by the funeral director, page 5 should be detached for us | or removal |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with-es hours after death. Page 6 may be retained by the hospital or a | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us | be filed within 72 hours after death with the State Deot. of Health and Mental Hydlene prior to burial, cremation |

attending physician. se as the burial-transit permit. Pages 1, 2, 3 should

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT | AL HYGIENE |
|---------------------------------------------------|------------|
| CERTIFICATE OF DEATH | REG NO |

| | 1 - STATE REGISTRAR | STATE OF MARYLAND | O / DEPARTMEN CERTIFICAT | T OF HEALTH AND | MENTAL HYGIENE REG. NO. | |
|--------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last RECTO | 2 D | HYS | lop | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 216-74-2249 | 5. SEX 1 M 2 D F 3 6. AGE (in yrs. | YRS. MONTHS | | 7. DATE OF BIRTH (Month, Day, Year) 0 - 16 - 1959 | 6. BIRTHPLACE (State or Foreign Country) M. J. |
| HOT | 90. FACILITY NAME (If not institution, give HESIDENCE OF DECEDENT | Ospital | 96. CIT | andalstin | EATH 9c. COI | Ba Hombre |
| DIRECTOR | 10a. STATE 10b. COUN | Ba Ho | 10c. CITY, TOWN | or Location Mas Mills | | 10d. INSIDE CITY LIMITS? 1 YES 2 ND |
| FUNERAL | | nar Court | | 101. ZIP CODE 21/17 | | TIZEN OF WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | MAS DECENDENT DF HISPA II yea, specify Cuban, Mexic 1 YES 2 NO Speci | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| LETED | 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | UCATION 16a. College (1-4 or 5+) | Ille. Do NOT use retired. | during most of working | 16b. KIND OF BUSINESS/IN | |
| once. | 17. FATHER'S NAME (First, Middle, Last) | Luclas | Never W | | AME (First, Middle, Melden Surneme) | , |
| be notified at once. TO BE COM | 190, INFORMANT'S NAME (Type/Print) | 74570 | 19b. MAILING ADDRES | Pondical Street and Number or Rural | Royte Number, City or Town, State, Zi | S 10 C000) d 2/207 |
| must be | 20a. METHOD OF DISPOSITION 1 | 20h. PyA | E AND DATE OF DISPO | | PATE 20c. LOCATION - | - City or Town, State |
| medical examiner must | 21. SIGNATURE OF FUNERAL SERVICE L | James M. Maria | Te. 22 | NAME AND ADDRESS OF FA | L. West | 21215 |
| # P | IMMEDIATE CAUSE (Fine) disease or condition | | line. | | ch as cardiac or respiretory at | Interval Between Onset and Death |
| matic event, the | resulting in death) | DUE TO (OR AS A CON | | | | 1710 |
| 1 1 2 E | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A CON- | | | | |
| | that initiated events resulting in death) LAST | DUE TO (DR AS A CON | SEQUENCE OF): | | | |
| ws amy in | Staphylococi | 11.1 | | | Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 AND | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 23 a | DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL | 26. PI | EATH YES | | N/E | 1 YES 2 2770 |
| 1, or item | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Sinpatient 2 ER/Outpatient | 3 DOA 4 Nu | R: rsing Home 5 - Residence | 8 Other (Specify) | |
| BY PH | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 ND | 28d. DESCRIBE HOW INJURY OC | CURED |
| m 28 li | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At building, etc. (Specify) | t home, lerm, street, lac | ctory, office | 281. LOCATION (Street end Number City or Town, State) | r or Rural Route Number, |
| PORTANT: If Item BE COMPLET | | SICIAN: To the best of my knowledge, IER: On the besis of exemination end/ | | | | |
| IMPORTANT: O BE CON | 29b. SIGNATURE AND TITLE DF CERTIFIE | Man My | | 29c. LICENSE NUI | 333 15 | TE SIGNED (Month, Day, Year) EP 8, 1997 |
| | 30. NAME AND ADDRESS OF PERSON W | MP, MAC | | 0. MD21 | 133 | |
| | 31. DATE FILED (Month, Day, Year) SEP 1 1 199 | 32. REGISTRAR'S SIGNATURE | Randall | | | |



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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within =4 hours after death. Page 6 may be retained by the hospital or attence | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as be filled within 72 hours after death with the State Debt. of Health and Mental Horiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| | 2 | 23 | ₹ | |

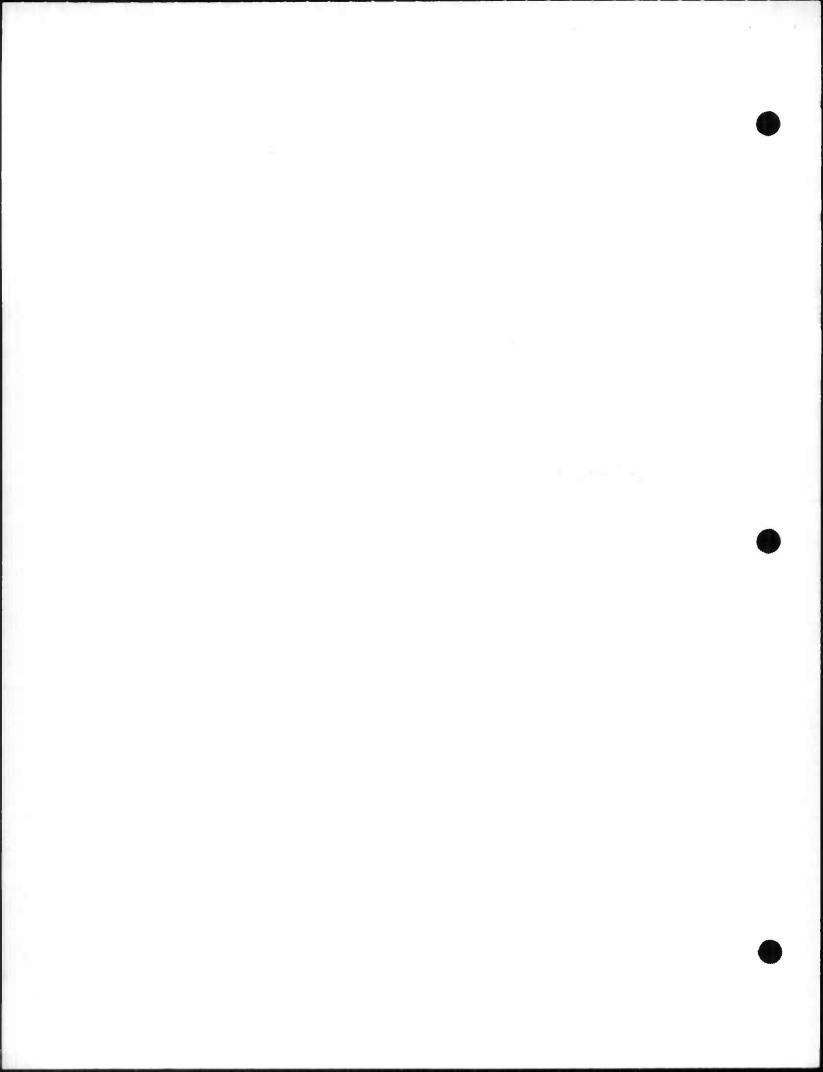
P2782 CHEAL 31. DATE FILED (Month, Day, Year) SEP111995

COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

2 KNOCC A 32. REGISTRAR'S SIGNATURE

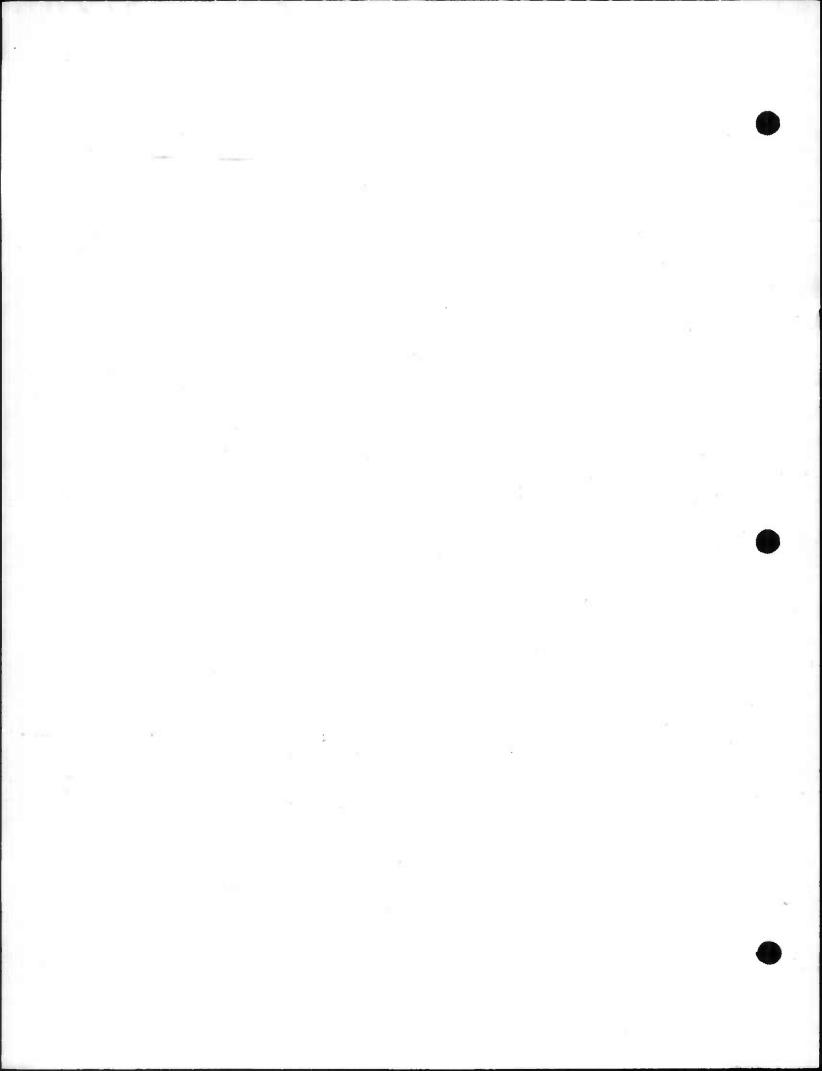
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| | REGISTRAR | MARYLAND C | / DEPARTMEN | NT OF HEA | LTH AND M | ENTAL HYGIEN | | | |
| | 1. OECEDENT'S NAME (First, Michile, Last) DOLORES HENDER | | | | | 2. DATE OF DEATH MONTH | 9 95 | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER 218–24–6603 S. SEX 1 \square M 2 \boxtimes F | 6. AGE (In yrs. In: | VRS. WONTH | | F UNDER 24 HRS. 7 | 7. DATE OF BIRTH (Mooth, per Year) AUG 23, 1 | .931 Pei | BIRTHPLACE (State or Foreign Country) nnsylvania | |
| TOR | 90. FACILITY NAME (# not institution, give street end number) Howard County General Hos | spital | | ity, town on L lumbia | OCATION OF DEAT | ГН | 9c. COUNTY Howard | | |
| DIRECTOR | 10a. STATE 10b. COUNTY Maryland Howard | | 10c. CITY, TOWN | N OR LOCATION | llicott | City | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | |
| FUNERAL | 104. STREET AND NUMBER 10772 Frederick Road | | | | 21042 | 10g. CITIZEN | OF WHAT COUNTRY? | | |
| В | 11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 3 Widowed 4 Divorced IF YES, GIVE | RMED 12 | | Cubert, Mexican, I | ORIGIN? (Specify Ye Puerto Rican, etc.) | ss or No— 14. RACE — American Indian, Black, White, etc. Specify White | | | |
| COMPLETED | 15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or secondary (0-12)) | OCCUPATION ne during most of d.) | l working | Home | ISINESS/INDUST | 'FY | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) Max Maynard Bequeat | h | | 18. | 18. MOTHER'S NAME (First, Middle, Melden Surname) Mildred Emma Ritchey | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Paul D. Henderson | ss (Street and A ederick | Vumber or Rural Rout Rd. E1 | ute Number, City or Tow licott Ci | ty, MD | ⁵⁰⁾ 21042 | | | |
| | 20e. METHOO OF DISPOSITION 1 Burley 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Members) 20c. LOCATION - City or Town, State A Donatton 5 Other (Specify) Baltimore, MD | | | | | | , MD | | |
| | George E. MacNabb | | 29 | 99 Fred | derick R | ty of Mar d. Baltin | nore, M | D 21228 | |
| | 23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one commendation is a commendation in the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock | nst ceused the de ause on each line O (OR AS A CONSE | leath. Do not ente | er the mode of | of dying, such s | ss cerdiac or resp | iratory srrest, | Approximats Interval Between Onset and Desth | |
| CERTIFICATION | resulting in death) LAST | | | | | | | 6 days 6 days 3 days 6 days | |
| MEDICAL (| PART II. Other eignificent conditions contributing to Phenometrical archive | | resulting in the u | underlying ca | use given in Ps | PERFORMANT 1 TYPES 2 | RMEO? | 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| | DID TOBACCO USE CONTRIBUTE TO CA | | ATH YES | | UNCERTAIN | | | 1 TES 2 ND | |
| BY PHYSICIAN: | 1 VES 2 NO 1 Nontient 2 27. MANNER OF DEATH 28e. DATE O | ER/Outpatient 3 DF INJURY Day, Year) | 3 DOA OTHE 4 No 28b. TIME OF INJURY | 28c. INJURY WORK? | FR: Irsing Home 5 Residence 8 Other (Specify) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCUREO | | | EO | |
| | 3 Suicide . Could 28e. PLACE | OF INJURY — At ho g, etc. (Specify) | ome, ferm, street, fe | ictory, office | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of | | | | | | | use(e) end menner ee stated. | |
| 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) of 29b. SIGNATURE AND TITLE DE CERTIFIER 29b. SIGNATURE AND TITLE DE CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIDNED (A | | | | | | | | | |

MO



| | | 1 - STATE OF MARYLAND / DEPARTMENT CERTIFICATE | OF HEALTH AND MENTAL HYGIENE E OF DEATH REG. NO. |
|------------------------------------------------------------------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) TAMES HEARY | 2. DATE OF DEATH MONTH DAY TH 95 6.30 PM |
| ā | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) F UNDER 1. SM 2 F S YRS. MONTHS | 1 YEAR FUNDER 24 HRS. DAYS HOURS MIN. TOWN OF LOCATION OF DEATH. TOWN OF LOCATION OF DEATH. |
| . 2. 3 should | стов | 9a. FACILITY NAME (If not institution, give street and number) = 9b. CTY, ALDERUM HOSP, FAIL ARSIDENCE OF DECEDENT | TOWN OR LOCATION OF DEATH OC. COUNTY OF DEATH NA |
| ift. Pages 1 | DIRE | 10a. STATE 10b. COUNTY 10c. CITY, TOWN O | OR LOCATION 10d. INSIDE CITY LIMITS? 1 D YES 2 \(\text{NO} \) NO |
| in. ransit permit. | FUNERAL | 2200 Linden Avenue | 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2/2/7 4. S.A. |
| 5-0020 nding physician. ss the burlal-transit | B⊀ | 1 Never Married 2 Married FORCES? 1 X YES 2 NO | MAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, etc. Specify: Specify: Black Specify: |
| 2121 bal or atte | LETED | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementsry/Secondary (0-12) College (1-4 or 5 +) Light College (1-6 or 5 +) | |
| YLAN by the hos be detach | | 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| y be retained page 5 should be notified | | | Parsons Drender Daltimore Md 21209 |
| e 6 m rector, | | 20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donastion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Forest 9/13/95 Owings Hills Md |
| death. I funeral | | Hala March 14 | and The House of Facility lest architect was a rist |
| within 24 hours after tolerely filled in by the cremation, or removal | | 23. PART I. Enter the disesses, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disesse or condition resulting in death) | tha mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death |
| 8 5 8 E | | | NONIA |
| certificate be execut ding physician and of lygiene prior to burit other traumatic | 101 | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | TITIAL LUNG DISEASE |
| 1 4 5 6 | | resulting in death) LAST d. MULTIPL | EM/LOMA. |
| that the sed by the h and M | MEDICAL | PART II. Other aignificent conditions contributing to death but not resulting in the un | PERFORMEO? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? |
| has the Dept | AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN 128, PLACE OF DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check of DEATH (Check | |
| CIAN: ertifica the St | \(\(\) | EXAMINER? 1 | ling Home 5 Residence 8 Other (Specily) |
| D F if if | ВУ Р | 1 Netural 5 Pending (Month, Day, Year) NJURY 2 Accident Investigation | 28c. INJURY AT WORK? 1 YES 2 NO |
| STOR STORY | iii | 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, straet, factor building, etc. (Specify) | City or Town, State) |
| 対域に 1 | Ž | 29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the till one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my or | me, data and place, and due to the cause(s) and manner as stated. pinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. |
| TO THE HOSPI TO THE FUNER De filed within | BE | 296, 84GNATURE AND TITLE OF CERTIFIER CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOCIO DE CONOC | 29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Year) \$\infty \text{TH 1995} |
| 7 | 10 | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward Obazee, M.D. c/o Maryla | |

31. DATE FILED (Month, Day, Year)
SEP 1 1 1995



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TS hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumstic event, the medical examiner must be notified at once. |
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FOR STATE REGISTRAR

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE | OF DEATH | | YEAR | 3. TIME OF DEATH |
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| | Daniel David Horwitz | | | | | | | | | | | 4:00pm |
| | 4. SOCIAL SECURITY NUMBER 286 01 3177 | | AGE (In yrs. lesi | | ONTHS D | | IF UNDER 24 HRS. | 7. DATE (Mont | OF BIRTH | | 8. BIRTH Country | PLACE (State or Foreign |
| | | 1 🖾 M 2 🗆 F | 82 | YRS. | | | | Aug | 2,1 | 913 | Ohi | O |
| . | 9e. FACILITY NAME (If not institution, give a | street and number) | | 9 | b. CITY, TO | OWN OR | LOCATION OF | DEATH | | 9c. COUN | TY OF D | EATH |
| DIRECTOR | Hebrew Home of Greater Washington/ Rockville Montgomery | | | | | | | | | | mery | |
| | 10e. STATE 10b. COUNT | Υ | | 10c. CITY, | TOWN OR L | LOCATIO | N | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Mont | gomery | | Che | vy C | has | se | | | | | 1 TES 2 NO |
| | 4808 Essex Ave | enue | | | | 8 | 0815 | | | USA | | HAT COUNTRY? |
| - 11 | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 | YES 2XN | | If ye | es, speci | NOENT OF HISPA Ify Cuben, Mexic | en, Puerto | | or No— | 14. RACE Black Specif | — American Indian, White, etc. |
| | 15. DECEDENT'S EDU | CATION | 440 050 | DEDENTAL | 1 | | | | | | hit | e |
| - | (Specify only highest grade | completed) | (Gi | CEDENT'S US ve kind of wor Do NOT use i | k done durir | ing most of | of working | 168 | . KIND OF BU | SINESS/INDU | USTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | 1 | ent | , | ine | er | υ | .S. F | aten | t O | ffice |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | 1 | 16. MOTHER'S N. | AME (First, | Middle, Meiden | Surname) | • | |
| | David Horwitz | | | | | | Minn | ie G | oreli | .ck | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | | | | | Number or Rural | | | | | 16901 |
| - 11- | Judith Canonic | 0.0 | R. | D. 6 | , Во | x 1 | 106, W | ells | boro, | Penn | sy1 | vaniā |
| | 20a. METHOD OF DISPOSITION 1 **XBurlel 2 **Cremetion 3 **CREME A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A **CREMET A | oval from State | 20b. PLACEA | | | | Gdns | 8 / 25 | E 20c. LO FA1 | | , | en, State ch VA |
| Т | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE / | | | 22. NA | ME AND | ADDRESS OF F | ACILITY | | | | |
| | De Summella | releulu | 1 | | | | Pearso | | | | es | |
| + | 23. PART I. Enter the diseasea, or o | | | oth Do not | Fal | ls | Churc | h, V | A 22 | .046 | | |
| | snock, or haart failure. | List only one cause of | on each line. | oth. Do not | dilla flie | e mode | e or dying, au | on aa can | diac or reapi | ratory arre | eat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition → Congestive Heart FAilure | | | | | | | | Onset and Death | | | |
| | reaulting in death) | | | t FA | 111 | ire | | | | | 4 month | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | Sequentially list conditions, b. Mitral insufficiency DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | months | | | |
| | If any, leading to immediate cause. Enter UNDERLYING | | | oc - n - ' | | | | | | | | |
| | CAUSE (Disease or Injury that Initiated events | DUE TO (OR | AS A CONSEQ | UENCE OF): | Lenc | _у | | | | | | months |
| CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| | resulting in death) LAST | d C | | | | | | | | | | vears |
| | resulting in death) LAST | d. Corona | | | | | | _ | | | - | 1 / |
| | PART II. Other algorificant condition | a contributing to dea | th but not re | suiting in | tha under | | | Part I. | 24s. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| | resulting in death) LAST | a contributing to dea | th but not re | suiting in | tha under | | | Part I. | | MED? | | |
| | PART II. Other algnificant condition Vertebral-1 | e contributing to dear casilar i | th but not re | icie | n c y | riying c | | Part I. | PERFOR | MED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | PART II. Other algnificant condition Vertebral-b | e contributing to dear casilar i | th but not re | icie | n c y | riying c | | | PERFOR | MED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| | PART II. Other algnificant condition Vertebral-t Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | e contributing to dear casilar i | n s u f f E OF DEAT | icie | Check only | one) | ceuse given in | NX | PERFOR | MED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | PART II. Other algnificant condition Vertebral-t Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN | a contributing to deal casilar i | th but not rensulf for DEAT 26. PLACE OUTpatient 3 | icie | NC Y Check only THER: | one) | UNCERTAL 5 - Residence | N 🔯 | PERFOR | MED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| | PART II. Other algnificant condition Vertebral-t Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | a contributing to deal casilar i | E OF DEAT 26. PLACE Outpatient 3 RRY BURY — At hon | TH YES E OF DEATH DOA ON INJUR | NC Y NC (Check only) THER: THER: THER: THER: THER: THER: THER: | one) Nome C. INJURY WORK | UNCERTAI | 6 Othe 26d. DES | PERFOR 1 YES 2 | MED? | URED | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| | PART II. Other algnificant condition Vertebral-I Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 **Netural** 5 Pending investigation 3 Sulcide 8 Could not be determined | A contributing to deal of a silar i RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/ 280. DATE OF INJU (Month, Day. 16 280. PLACE OF INJ building, etc. (| E OF DEAT 26. PLACE Outpetlent 3 RRY BIRTY — At hone | FH YES FOR DEATH DOA 4 286. TIME C INJUR | In C y NC (Check only) THER: Tyurning FY M 1 et, factory, | one) Nome L. INJURY WORK YES | UNCERTAI 5 Residence W AT 77 7 2 NO | 6 Othe 26d. DES | PERFOR 1 YES 2 If (Specify) GCRIBE NOW II ATION (Street a or Town, Stete) | MED? MO NURY OCCI | URED or Aural Re | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| | PART II. Other algnificant condition Vertebral-I Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | A contributing to deal of a silar i RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/ 28e. DATE OF INJU (Month, Day, 16 28e. PLACE OF INJ building, etc. (| th but not re n s u f f E OF DEAT 26. PLACE Outpatient 3 TRY arr) URY — At hon Specify) (nowledge, des | FH YES FOR DEATH DOA 4: 286. TIME C INJUR | INC Y NC (Check only) THER: Typinsing F 28c Y M 1 et, factory, | Nome c. INJURY WORK VES office | UNCERTAI 5 Residence NY AT 77 2 NO | 6 Other | PERFOR 1 YES 2 If (Specify) SCRIBE NOW II ATION (Street a or Yown, Stete) | MED? NO NJURY Occi | URED or Rural Ru | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| | PART II. Other algnificant condition Vertebral—I Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending investigation 3 Suleide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | ACCONTIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/ 28e. DATE OF INJUITIES. 28e. PLACE OF INJUITIES. CIAN: To the best of my k | th but not re n s u f f E OF DEAT 26. PLACE Outpatient 3 TRY arr) URY — At hon Specify) (nowledge, des | FH YES FOR DEATH DOA 4: 286. TIME C INJUR | INC Y NC (Check only) THER: Typinsing F 28c Y M 1 et, factory, | one) Nome Nome North VES office | UNCERTAI 5 Residence Y AT 77 8 2 NO nd place, end due th occured at the | 6 Othe 26d. DES 26f. LOC City to the cau | PERFOR 1 YES 2 If (Specify) SCRIBE NOW II ATION (Street a or Yown, Stete) | MED? NJURY Occurrent Number of the state of the total due to the | URED or Aural Add. cause(e) | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO oute Number, and menner as stated. |
| | PART II. Other algnificant condition Vertebral-I Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | ACCONTIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/ 28e. DATE OF INJUITIES. 28e. PLACE OF INJUITIES. CIAN: To the best of my k | th but not re n s u f f E OF DEAT 26. PLACE Outpatient 3 TRY arr) URY — At hon Specify) (nowledge, des | FH YES FOR DEATH DOA 4: 286. TIME C INJUR | INC Y NC (Check only) THER: Typinsing F 28c Y M 1 et, factory, | one) Nome Nome North VES office | UNCERTAI 5 Pasidence 7 AT 77 8 2 NO | 6 Othe 26d. DES 28f. LOC City time, date | PERFOR 1 YES 2 If (Specify) SCRIBE NOW II ATION (Street e or Town, Stele) | MED? NO NJURY Occi | URED or Aural Add. cause(e) | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO oute Number, and menner as stated. |
| | PART II. Other algnificant condition Vertebral—I Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending investigation 3 Suleide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/ 28e. DATE OF INJU- (Month, Day. Ve 28e. PLACE OF INJU- building, etc. (CIAN: To the best of my k R: On the basic of examin | th but not re n s u f f E OF DEAT 26. PLACE Outpatient 3 RRY Specify IURY — At hon Specify (nowledge, dea | FIH YES OF DEATH DOA 4: 28b. TIME C NUUR NUUR The occurred of twestigation, | INC Y INC Y ICheck only ITHER: Tyurning IF 28c Y M 1 et, factory, at the time, in my opink | one) Nome c. INJURY WORK YES office | UNCERTAI 5 Residence Y AT 77 8 2 NO | 6 Othe 26d. DES 26f. LOC City to the case time, date MBER 3 9 5 2 | PERFOR 1 YES 2 If (Specify) SCRIBE NOW II ATION (Street a or Yown, State) | MED? IX NO NJURY OCCI Out of the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of d | d. cause(e) | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO oute Number, and menner as stated. Month, Dey, Year) |
| | PART II. Other algnificant condition Vertebral-1 Dementia DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 No 27. MANNER OF DEATN 1 Netural 5 Pending investigation 3 Suleide 8 Could not be determined 29e. CERTIFIER (Chack only 2 MEDICAL EXAMINER) 29b. SIGNATURE ND TITLE OF CERTIFIER | RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/ 28e. DATE OF INJU- (Month, Day. Ve 28e. PLACE OF INJU- building, etc. (CIAN: To the best of my k R: On the basic of examin | E OF DEAT 26. PLACE Outpettent 3 IRY INFO At home Chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, death chowledge, | FIH YES OF DEATH DOA 4: 28b. TIME C NUUR NUUR The occurred of twestigation, | INC Y INC Y ICheck only ITHER: Tyurning IF 28c Y M 1 et, factory, at the time, in my opink | one) Nome c. INJURY WORK YES office | UNCERTAI 5 Residence Y AT 77 8 2 NO | 6 Othe 26d. DES 26f. LOC City to the case time, date MBER 3 9 5 2 | PERFOR 1 YES 2 If (Specify) SCRIBE NOW II ATION (Street a or Yown, State) | MED? IX NO NJURY OCCI Out of the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of due to the state of d | d. cause(e) | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO oute Number, and menner as stated. |

. .

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital or attending physician.

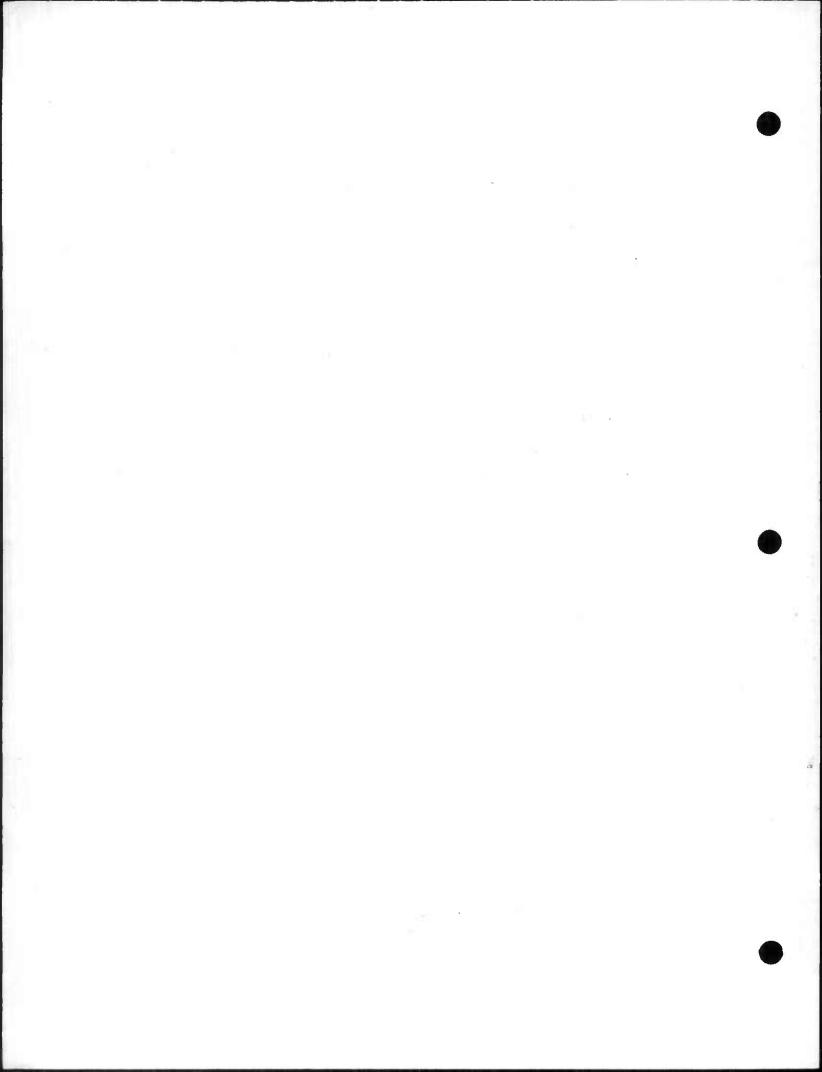
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

| _ | HEGIOTIAN | | | ENTIF | ICALE | UF | DEAL | | F | REG. NO. | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------|--------------------------------------------------------------|-------------------------------------------|----------------|-------------------|-----------------|-------------------------------------------|----------------------------------------------|--------------|-------------------|--------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) Leslie | | НО | DSON | | | | | 2. DATE OF MONTH AUgus | DEATH | ,199 | 5 ^{YEAR} | 3. TIME OF DEATH 6:15 P M |
| | 4. SOCIAL SECURITY NUMBER 212-34-6671 | 5. SEX | 6. AGE (In yrs. Is | est birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. MIN. | 7 DATE OF | _ | | | IPLACE (State or Foreign y) |
| 1 | 9a. FACILITY NAME (If not institution, give s | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | | EATH | | | |
| DIRECTOR | Franklin Square H | Iospital | | | Rosedale | | | | | | Baltimore | | |
| EC | 10a. STATE 10b. COUNTY | 10c. CIT | Y, TOWN O | R LOCAT | ION | | | | 10d. INSIDE CITY | | | | |
| ā | Maryland Balti | 1 | liddl | e Ri | ver | | | | |): I | LIMITS? | | |
| M | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | | | 10g. CI1 | IZEN OF W | HAT COUNTRY? | | |
| ij | 22 Old Orems Road | | | | | | 2122 | 0 | | | | u.s. | A |
| Y FUNERAL | 11. MARITAL STATUS 11. MAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | | | - 3 | f yes, sp | ENDENT O | n, Maxicai | IC ORIGIN? (S 1, Puerto Rica | pecify Yes n, etc.) | or No— | | — American Indian, , White, etc. |
| ВУ | 3 Widowed 4 Divorced | | | | | | 2 (3 1.10 | ороспу | | | | Specia | white |
| ĬĮ. | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (0 | ECEDENT'S | work done o | CCUPATIO | N st of workin | g | 16b. Kill | ID OF BUS | INESS/IN | DUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+ |) " | b. Do NOT us | se retired.) | | | | Cux | אווא | Mino | ral (| Corporation |
| OM | 17. FATNER'S NAME (First, Middle, Last) | | | 18. MOTNER'S NAME (F | | | | | | | | | остеротальского |
| BE C | | | | | | | | | | | , | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | 15 | 9b. MAILING | ADDRESS | (Street a | nd Number | or Rural F | loute Number, (| City or Town | n, Stata, Zi | p Code) | |
| | Bill Vandaniker | | | | | | | | | | | | |
| | 20a. METNOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | State | | CEAND DATE OF DISPOSITION (Name of crematory or other piece) | | | | | DATE | DATE 20c. LOCATION — City or Town, State | | | |
| | State Anatomy Board-655 W. Baltin | | | | | | | more Street | | | | | |
| _ | Janan/ | Wille | ee. | | Rm | .B02 | 6-Ba | ltim | ore, 1 | laryl | and | 212 | 01-1559 |
| | 23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heert fellure. List only one ceuse on eech line. | | | | | | | | | Approximate interval Batween Onset and Daath | | | |
| | disease or condition resulting in death) | ia | A CONSEQUENCE OF: | | | | | | | 2months | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): Bronchogenic carcinoma | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | DUE TO | OD AS A COME | OUENOE O | | | | | | | | | |
| | that initiated eventa resulting in deeth) LAST | DUE 10 (| OR AS A CONSE | QUENCE OF | F): | | | | | | | | |
| CE | | - | | | | | | | | | | | 1 |
| EDICAL | PART II. Other aignificent condition | contributing to | deeth but not | reaulting I | uiting in the underlying couse given in P | | | | Part I. 24s. WAS AN AUTOPSY PERFORMED? | | | 246. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| ă | | | | | | | | | 1 | YES 2 | ₩ NO | | COMPLETION OF CAUSE OF DEATH? |
| 2 | DID TOP ACCOUNTS CONTROL | NOUTE TO CAL | | | | | | | | | | | 1 - YES 2 - NO |
| AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one) | | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | | OTHER | 1: | | | | | | | |
| Ĭ | 27. MANNER OF DEATN | 28a. DATE OF | INJURY | 28b. TIM | E OF | 28c. INJI | JRY AT | sidence (| 28d. DESCRI | | JURY OC | CURED | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Da | ny, rear) | INJ | M | 1 N | | NO | | | | | 1.00 |
| COMPLETED | 3 Suicide 6 Could not be detarmined | 28e, PLACE OF building, | FINJURY — At he etc. (Specify) | ome, farm, i | dreet, facto | ory, affici | 1 | | 28f. LOCATIO City or To | N (Street al wn, State) | nd Number | r or Rural R | oute Number, |
| ١٣ | 29a. CERTIFIER (Check only | CIAN: To the best of | my knowledge, de | eath occum | of at the ti | me dete | and place | and due | o the same | \ | | and . | |
| 8 | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | and manner ea stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICE | | | | | | (Month, Day, Year) |
| 8 | mut ? | too | | | | | 22 | 18 | 46 | | 1 | 8/3, | 185 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | | 101, | |
| | Dr. Martin Sherid | | | n Squ | are | Dr. | Balt | imor | e, Ma | ry1ar | nd 21 | 1237 | |
| | SEP11 1995 | 32. REGISTRAL | ON ADMA | 2 | | | | | | | | | |
| | OFI TT 1223 | man wants | we could | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the business that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

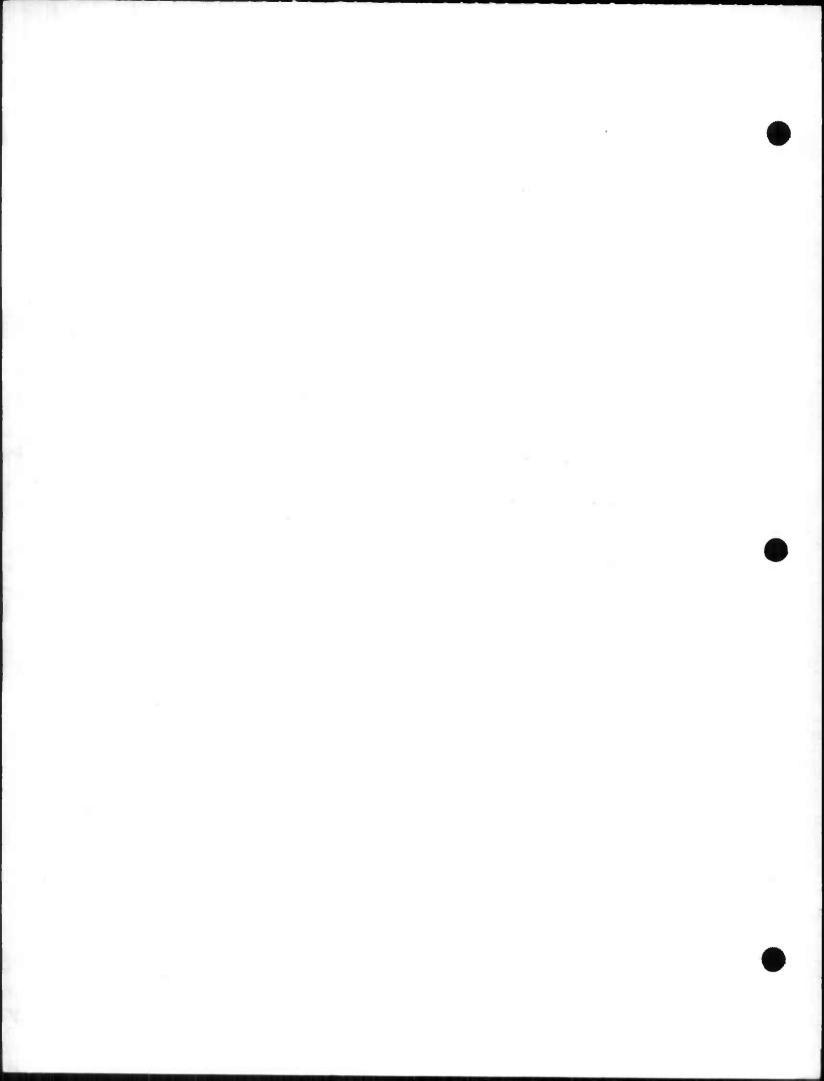
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1. DECEDENT'S NAME (First, Middle, Lest) CLTFFORD | HICKS | | | | - | | | 2. DATE OF D | DEATH DAY | 2.19 | YEAR | 3. TIME OF DEATH 5:27 A M |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------|----------------------------------------|--------------|----------|---------------------------|---------|------------------|-------------|------------|-----------|----------------------------------------------------|
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In vo | s. lest birtnday) | IF UNDER 1 1 | YEAR | IF UNDER | 24 HRS | 7. DATE OF 8 | | | | IPLACE (State or Foreign |
| 214-64-2505 | 1 X M 2 F | | | | DAYS | HOURS | MIN. | (Month, Day | y, Year) | | Countr | γ) |
| 9a. FACILITY NAME (If not institution, give s | treet and number | | | 9b. CITY, TO | O NWO | B LOCATIO | N OF DE | | 6-195 | 9c. COUNT | | yland |
| 727 DRUID PARK | | | | | | MORE | | | | JC. 000KT | , or o | POLIT |
| RESIDENCE OF DECEDENT | v | | I so CITY | , TOWN OR | LOCATI | ION. | | | | | | 10d. INSIDE CITY |
| Maryland | ' | | | Baltin | | | | | 5.3 | | | LIMITS? |
| 10a. STREET AND NUMBER | | | | | 101. | ZIP CODE | | | | 10g. CITIZ | EN OF V | VHAT COUNTRY? |
| Whitelock | Street | | | | : | 21217 | 7 | | | и | .S. | 4. |
| 11. MARITAL STATUS | 12. WAS OECEDEN' FORCES? 1 | EVER IN U.S | S. ARMED | | | | | NIC ORIGIN? (S | | or No — | t4. RACI | E — American Indian, k, White, etc. |
| 1 [X] Never Married 2 Married 3 Widowed 4 Divorced | IF YES GIVE W | AR OR DATES | -76 | | | 2 € NO | Specifi | | 1, 010.7 | | | w Black |
| 15. DECEDENT'S EDU | | 16: | . DECEDENT'S | | | | | 16b. KIN | D OF BUSI | NESS/INDU | STRY | |
| (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 + |) | (Give kind of w life. Do NOT use | e retired.) | ning mos | St OF WORKIN | 9 | | | | | |
| 12 | | | Labore | er | | | | Co. | nstru | ictio | n | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | ME (First, Middl | | lumame) | | |
| Clifford Hicks, S | r. | | | | | Ethe | el B | rookin | S | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number, C | | | | |
| Ethel Hicks | | | | | | | ret- | Baltim | | | | |
| 20a. METHOD OF DISPOSITION 1 Denision 5 Cother (Specify) in 12 | | | ACE AND DATE Or ry, crematory or ot | | ION (Nei | me of | | DATE | 20c. LOC | ATION C | Ity or To | wn, State |
| 21. SIGNATURE OF UNERAL SERVICE LIC | | Wade | Dir. | | | D ADORES | | | | | 0.4 | |
| John 16 | Cheece | | , | | | | | | | | | imore Street 201-1559 |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) | | se on each | line. | | | | ng, suc | th as cardlec | or respin | atory srre | est, | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C | | ONSEQUENCE OF | | | | | | | | | |
| PART II. Other significent condition | ns contributing to | deeth but | not resulting I | In the und | erlying | cause (| lven In | Part I. 24 | n. WAS AN | AUTOPSY | 246 | . WERE AUTOPSY FINDINGS |
| | | | | | | 101 | | | PERFORI | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | - 1 | YES 2 | NO | | OF DEATH? |
| DID TORACCO HEE COLUM | DIDLITE TO CA | LICE OF | DEATH V | с Г ·· | 0 - | 11110 | EDTA | | | | | t TYES 2 NO |
| DID TOBACCO USE CONT | KIBUIL IO CA | | PLACE OF DEAT | | | 1 UNC | ERTAI | Т | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 0.0 | | OTHER: | | | | v | CC | יםואיםי | | |
| | 1 Inpetient 2 | | | 4 Nurair | | | sidence | | | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF (Month, D | lay, Ybar) Fo | 21-4 (28b. TIM INJ | URY | WO | URY AT PRK? YES 2 5 | ₹NO | Subje | | Tumo | - / | from Rock |
| 2 Accident Investigation 3 Suicide 8 Could not be | 28e, PLACE 0 | | At home, farm, s | | | * | | 281. LOCATIO | | | _ | Route Number. |
| 3 Could not be 4 Homicide detarmined | building, | etc. (Specify) | | suild | | | | City or To | own, State) | wid | Pur | 1500mmuno |
| | ER: On the best of | | | | | | | | | | | e) and menner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIE | R 9 | LL | - | | | | C . M | | | AU(| | T 22, 1995 |
| 30. NAME AND ADDRESS OF PERSON WI | Parler | 1: | 11 Pen | n St | re | et, | Bal | timor | e, N | lary. | lan | d 21201 |
| 31. DATE FILED (Month, Day, West) SEP11 195 | 32. REGISTA | ARIO SIGNATU | ine hardall | | | | | | | | | |



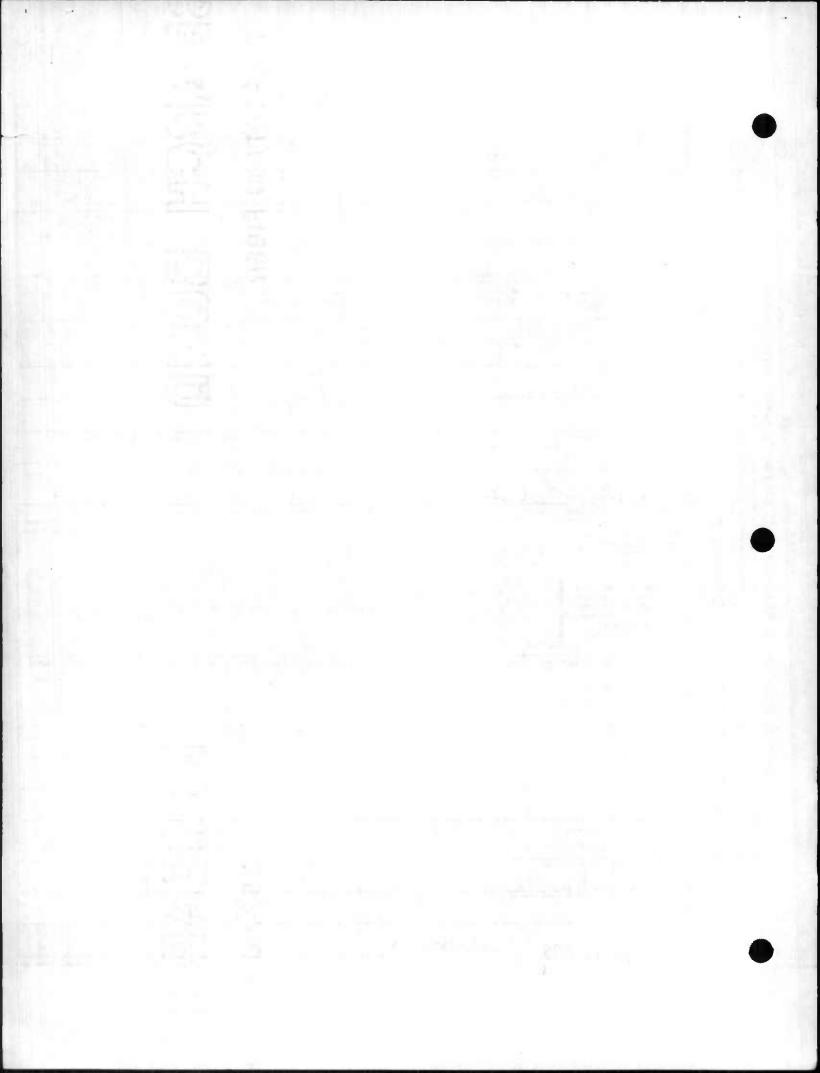
age 6 may be retained by the hospital or attending physician. director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the study of the state has been with the Case have been at the case of the state has a state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th | IMPORTATION IN THE 28 is marked, or teem 23 shows any injury, or other transactic event, the medical examiner must be notified at once. |
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| DR | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first within 72 hours after death with the State Date of Health and Martal House prior to build returnation for removal | ile. |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | ICATE O | FUEATH | REG. NO |), | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------|------------------------|---------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last HAYRIS, B | 484 BOY | | | | 2. DATE OF DEATH | MY Y | S 20:45 p m |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGI | (In yrs. last birthday) VRS. | F UNDER 1 YEAR | | 7. DATE OF BIRTH (Month, Day, Year) 2(6) | 55 15 | BIRTHPLACE (State or Foreign Epunts) AUTHORE CITY |
| OR | MERCY HUSPIT | _ | | BAL | N OR LOCATION OF | | 9c. COUNTY | BANKE CO |
| 5 | RESIDENCE OF DECEDENT | | | | | | | |
| DIRECTOR | 100. STATE 100. COUN BM | | 174 B/ | NTOWN OR LO | URE | | | 10d. INSIDE CITY LUMITS? 1. YES 2 NO |
| FUNERAL | | RAN STRE | ZET, | | 101. ZIP CODE 21 1 | 33 | 10g. CITIZER | N OF WHAT COUNTRY? |
| ВУ | 11. MARIMAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR | 8 2 NO | If yes, | | ANIC ORIGIN? (Specify Ye can, Puerto Rican, etc.) elfy: | s or No 14 | . RACE — American Indian, Black, White, etc. Specify: |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | UCATION to completed) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of life. Do NOT u | work done during | | 166. KIND OF BU | SINESS/INDUS | TRY |
| E COM | 17. FATHER'S NAME (First, Middle, Last) | DWN | | | | | | |
| TO BI | 190. INFORMANT'S NAME (Type/Print) Tandrea Harris | | 19b. MAILING | ADDRESS (Street | at end Number or Rura | I Route Number, City or Tov | vn. State, Zip Co | rde) |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Red 4 Donation 5 Other (Specify) | | Db. PLACE AND DATE ometery, crematory or co | | (Name of | DATE 20c. LC | CATION — City | y or Town, Stata |
| | 21. BIGHATURE OF TUNERAL SERVICE L | ICENSEE RONALD W | ade, Vir. | State Rm. B | AND ADDRESS OF I | Board-655 more, Mary | W. Ba | ltimore Street |
| | 23. MART I. Enter the disease, or shock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | complications that cause on CARD/A | each line. | not enter tha | noda of dying, su | ich aa cardlec or resp | iratory errest | t, Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): PREMATURE BIRTH 22 WEEUS GESTATION DUE TO (OR AS A CONSEQUENCE OF): | | | | | | 7 M/N |
| 띩 | Total ling in occur) Exor | d | | | | | | |
| MEDICAL | PART II. Other algorificant condition | ona contributing to deeth | but not resulting | In the underly | ing cause given i | Part I. 24a. WAS AN PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO |
| Ä | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | |
| 2 | EXAMINER? | HOSPITAL: | -1.5 | OTHER: | PLACE OF DEATH (| | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. Till | IE OF 28c. | NJURY AT WORK? | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | RED |
| ED BY | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e PLACE OF INJUS | RY — At home, farm, becility) | | YES 2 NO | 281. LOCATION (Street City or Town, State | and Number or | Rural Route Number, |
| COMPLETED | | SICIAN: To the best of my kno | | | | | | |
| 8 | 2 MEDICAL EXAMIP | | lon end/or investigation | on, in my opinior | , death occured at the | ne time, data and place, a | nd due to the c | ause(a) and manner as stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIC | Mp. Sevia | Resident | Pediah | 29c UCENSE N | SOC | 29d. DATE S | IGNED (Month, Day, Year) 27/97 |
| | 30. NAME AND ADDRESS OF PERSON W | ,22 S. GREE | VE ST. | RUDM | DEW EK | BATTME | PE MT | 121201 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | MATURE CONTRACTOR | | | 0 | | |
| | SEP 1 1 199 | Java whom | | | | | | |



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| | | FOR 1 - STATE REGISTRAR | TATE OF MARYLAN | | TMENT OF H | | MENTAL HYGIEN REG. NO. | _ | es & New York Manager |
|-----------------------------------------------------------------------|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------|-----------------------------------------|---------------------------------------------------------|-----------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) ROMAINE | | YNEX | | | 2. DATE OF DEATH ON SEPTEMBER | AY O YEAR | 3. TIME OF DEATH 06: 50 A M |
| pin | | | □ M 2 🔀 F | 72 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 16, | 1923 Ma | aryland |
| 1, 2, 3 should | TOR | Sinai Hospital RESIDENCE OF DECEDENT | ina number) | | Balti | MOTE | ATN | sc. COUNTY OF | DEATH |
| permit. Pages 1, | DIRECTOR | Maryland 106. COUNTY n/a | | 10c. CITY | , town on Locat Baltimo | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 25 | FUNERAL | 1031 North Bentalou | | | | 21216 | | USA | WHAT COUNTRY? |
| | COMPLETED BY FU | 1 Never Married 2 Married | WAS DECEDENT EVER IN U. FORCES? 1 YES 3 | 2 XINO | if yes, sp | ENDENT OF HISPAN ecify Cuben, Mexice 2 NO Specify | IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.) | or No— 14. RAC Blac Spec | E — American Indian, ik, White, etc. offy: Black |
| tal or attending for use as the | | | IN 16 Noted) 16 Hege (1-4 or 5+) | (Give kind of w life. Do NOT us | | ON st of working | 16b, KIND OF BUS | | 24,461 |
| be detached for at once. | | High School. 17. FATHER'S NAME (First, Middle, Last) | | Domes | stic | COM- | ME (First, Middle, Maiden | Family | |
| retained to 5 should notified | TO BE | John C. Gough 196. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural F | ia Taylor Noute Number, City or Town | | |
| e 6 may be ector, page must be | | Alonzo Joyner 20e. METHOD OF DISPOSITION 1 Burlel 2 X Cremation 3 Removal 1 4 Donation 5 Other (Specify) | Irom State cemeter | | Cairfax DEFISEOSITION (Na ther place) | | Septi | Maryland cation — city or t tonsvill | own, State |
| death. Pag funeral dir sxaminer | 8 | 21. SIONATURE OF FUNERAL, SERVICE LICENSE | | ZO OLCI | 22. NAME AN 2501 (| Gwynns Fa | Nutter F | Funeral 1 | Homes, Inc. |
| hours aft od in by or remo | | 23. PART I. Enter the diseases, or comp shock, or haert failure. List of IMMEDIATE CAUSE (Final | only one ceuse on each | e deeth. Do n line. | ot enter the mo | de of dying, such | cyland 212 | ratory erreet, | Approximata Intervel Between Onset and Death |
| within poletely cremati rent, t | | disease or condition resulting in deeth) a | SEPSIS DUE TO (OR AS A CO | INSEQUENCE OF | 7): | | | | |
| certificate be execuding physician and Hygiene prior to bur reumatiin | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CO | VAGII | MAL /E | MIROV | 'ESICLE | PISTUL | A |
| signed by the Health and Me | MEDICAL C | PART II. Other algnificent conditions con | COLON C | not resulting in | n the underlying | g ceuse given in | Part I. 24s. WAS AN PERFOR 1 TYES 2 | MED? | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| law Sept. | PHYSICIAN: 1 | | 26. | PLACE OF DEAT | H (Check only one) OTHER: | UNCERTAIN | | | |
| PHYSICIA this certif with the rrked, or | BY PHYS | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | Inpatient 2 ER/Outpatie 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 26c. INJI | URY AT RK? | 8 ☐ Other (Specify) 28d, DESCRIBE HOW IN | JURY OCCURED | |
| OR ATTENDING DIRECTOR: After hours after death them 28 is ma | ETED 8 | 3 Suicide 6 Could not be 4 Nomicide determined | 28e. PLACE OF INJURY — building, etc. (Specify) | A1 home, 1erm, s | treet, lectory, office | | 281. LOCATION (Street at City or Town, Stete) | nd Number or Rural | Route Number, |
| 対 以及 三 | COMPLI | | To the best of my knowledg the bests of exemination en | | | | | | s) and manner es stated. |
| TO THE HOSPI TO THE FUNER be filed within | TO BE (| 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COM | PUSMO MPLETED CAUSE OF DEATH | (ITEM 27) /3/00 | Parise 1 | 20c. LICENSE NUM AS240232 | 19813B | ▶ 90 PT | Month, Day, Year) |

BACTIMORE MY

2401 W. BELVA DEME

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

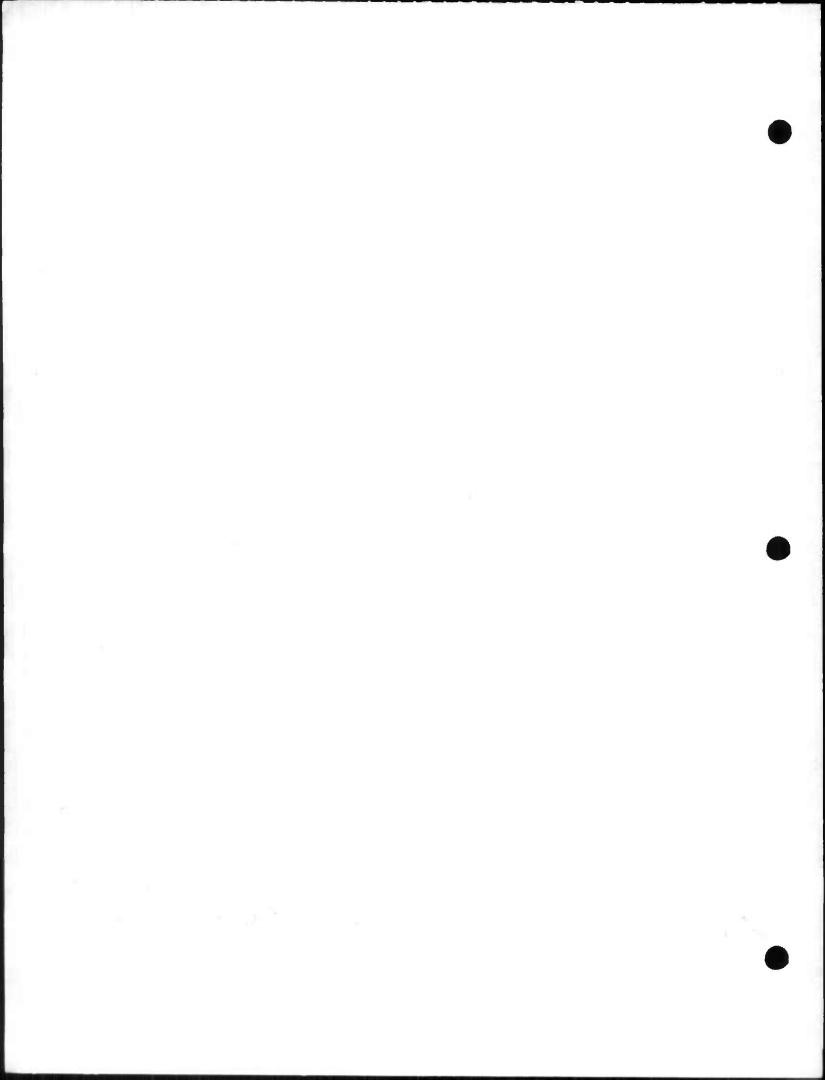
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | REGISTRAR | | CE | ERHE | ICAII | E OF | DEATH | RE | G. NO. | | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------|---------------------------------------|--------------------------------------|----------------------|-------------|----------------------------|-----------------------------------------------------------------|------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lust) RUBY | | JOH | NSON | | | | 2. DATE OF D MONTH SEPT. | DAY | | YEAR 95 | 3. TIME OF DEA | тн А м |
| | 4. SOCIAL SECURITY NUMBER 220-18-7831 | 1 🗆 M 2 🕽(FX | GE (In yrs. les | t birthday) YRS. | IF UNDER | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BI (Month, Day, 12- | итн 15–2 | | 8. BIRTH Countr | PLACE (State or F y) VA | Foreign |
| TOR | 90. FACILITY NAME (If not institution, give s 2000 O'DELL AV RESIDENCE OF DECEMENT | | .122 | 4 | 0.00 | | MORE CI | | | 9c. COUNT | n, | | |
| DIRECTOR | 10a. STATE 10b. COUNTY MD n/a | 1 | | | y, town | | | | | | | 10d. INSIDE CIT LIMITS? | |
| FUNERAL | 10e. STREET AND NUMBER 2000 Odell Ave | | | | | 101 | 21224 | | | | EN OF V | YHAT COUNTRY? | |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried 3737 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | YES 2 1 | MED | | If yea, sp | ecity Cuban, Maxica | in, Puerto Rican, | | or No— | 14. RACE Black Speci | - American Ind c, White, etc. | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | (G life | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | | |
| ₩ | 12th | | I | Nurs | es . | Aide | | | | ital | L | | |
| 8 | 17. FATNER'S NAME (First, Middle, Last) | | | | | | 16. MOTHER'S NA | | | | | | |
| BE | Nick Waddy | | | | | | Mil Mil | dred I | Wadd | У | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19 | | | | and Number or Rural | | | | | | |
| ٦ | Jacqueline Bur | man | | 4 | Cle | men | tine Ct | . apt | . 2d | Ba] | lto | ., MD | 212: |
| | 20b. METNOD OF DISPOSITION MCBurial 2 Cremetion 3 Removal from State | | | and date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the date of the da | thernlere | | Park | | 9/9 Randallstown, MD | | | | MD |
| | 21. SIGN OF PUNERAL SERVICE LIC | CENSEE | 100 | | J | ame | nd address of fa S A. Mo Lauren | rton 8 | | | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evanta resulting in death) LAST | с | AS A CONSE | OUENCE O | F): | 2010 | vs aus | on DIS | . FAS | € | | | |
| EDICAL CER | PART II. Other significant condition | d | th but not | resulting | in the u | nderiyin | g ceuse given in | 10 | WAS AN A PERFORM | NO NO | | . WERE AUTOPSY AMAILABLE PRIOF COMPLETION DF OF DEATH? | CAUSE |
| Σ | DID TOBACCO USE CONT | RIBUTE TO CAUS | | | | NO L | UNCERTAI | No I | INS PE | Mon | | 1 VES 2 🗆 | NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1X YES 2 NO | HOSPITAL: 1 Inpatient 2 ER | | DOA | OTHE | R: | ne 5 🖳 Raaldence | 6 Other (Spe | eolfy) | | | | |
| BY PH | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJU (Month, Day, Y | | 28b. TIM IN, | IE OF JURY M | WC | JURY AT DRK? YES 2 NO | 28d. OESCRIB | E HOW IN | JURY OCCI | URED | | |
| | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF IN- building, atc. | JURY — At ho (Specify) | ome, term, | street, tec | tory, offic | 10 | 28f. LOCATION City or You | | nd Number o | or Aurel I | Route Number, | |
| COMPLET | TOTAL OTHY | ICIAN: To the best of my | | | | | | | | | | a) and manner as | stated. |
| | SIGNATURE AND TITLE OF CERTIFIE | A, | | | | | 29c. LICENSE NU | MBER | T | 29d. DATE | SIGNED | (Month, Day, Year | -) |
| BE | Would to () | 6.11 | | | | | O.C.M. | E | | | | 06,199 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WH MARYARITO A. KO | RELLIME | 111 | Pen | | tree | t, Bal | | , Ma | | | | |
| | SEP1 1 1995 | 32 REGISTRAR'S | | | | | | | | | | | |



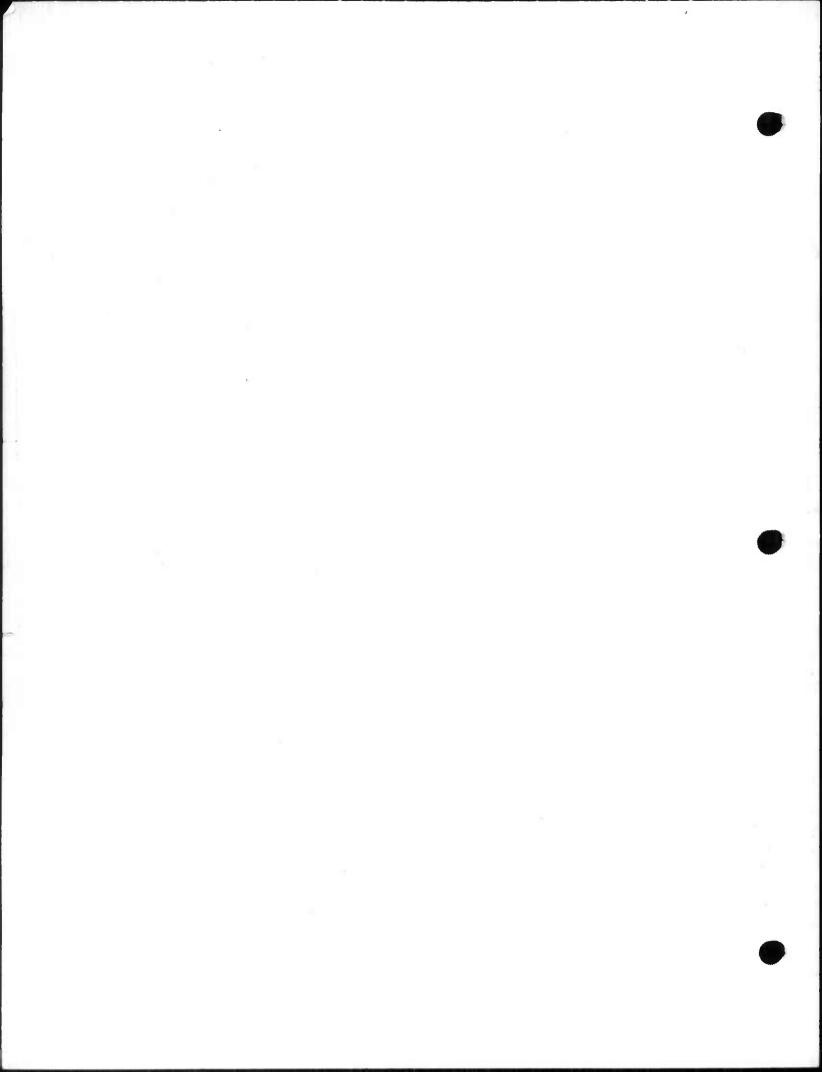
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DIVISION OF VITAL RECORDS P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 0. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3. TIME OF DEATH |
| DAY YEAR |
| 1,1995 17.44 P. M |
| 8. SIRTHPLACE (State or Foreign Country) |
| 908 VirginiA |
| 9c. COUNTY OF DEATH |
| 1//// |
| |
| 10d. INSIDE CITY |
| 1 FYES 2 NO |
| 10g. CITIZEN OF WHAT COUNTRY? |
| 11,5,4 |
| es or No.— 14. RACE — American Indian. |
| Stack, White, etc. |
| Black |
| USINESS/INDUSTRY |
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| DWN HOME |
| on Surgame) |
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| Jones |
| wn, Stete, Zip Code) |
| 11/12/Cs 602/2 |
| OCATION — City or Town, State |
| Alto, Co. md. |
| LINE Home |
| a delta |
| BAllimore Majon |
| piratory arrest, Approximeta Interval Between |
| Onset and Death |
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| N AUTOPSY 24b. WERE AUTOPSY FINDINGS |
| ORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| ORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| ORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| ORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ORMED? AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH! 1 YES NO |
| AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES NO INJURY OCCURED |
| AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES NO |
| AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES NO INJURY OCCURED and Number or Rural Floute Number, |
| AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES NO INJURY OCCURED and Number or Rural Route Number, |
| AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES NO INJURY OCCURED and Number or Rural Floute Number, |
| AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 VES NO INJURY OCCURED and Number or Rural Route Number, and to the cause(e) and manner as stated. |
| AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 VES NO INJURY OCCURED and Number or Rural Route Number, and to the cause(e) and manner as stated. |
| AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 VES NO INJURY OCCURED and Number or Rural Route Number, and to the cause(e) and manner as stated. |
| AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 VES NO INJURY OCCURED and Number or Rural Route Number, and to the cause(e) and manner as stated. |
| AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 VES NO INJURY OCCURED and Number or Rural Route Number, 9) |
| |



Item1,g-727,9-11-95,perf.h.,dk

| | | FOR STATE REGISTRAR | | / DEPARTMENT OF H | | IENTAL HYGIE | | |
|-----------------------------------------------------------------------|-------------|---------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------|---------------------------------------------|--------------------|-----------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH | DAY Y | 3. TIME OF DEATH |
| | | JAMES Henry | #5 | JONI | | 10000 | | 95 9:17 P. |
| Pir | | 215-30-9654 | 5. SEX 6. AGE (In yrs. 1) 1 1 2 F 58 | YRS. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 1936 N | BIRTNPLACE (State or Foreign Country) |
| 3 should | Œ. | 9e. FACILITY NAME (If not institution, give str | | | MORE CI | | 9c. COUNTY |) A |
| s 1. 2. | CTOR | 1646 E. COLDSPR | NG LANE | 10c, CITY, TOWN OR LOCATI | | 11 | 1 1 | 10d, INSIDE CITY |
| it. Page | L DIRE | Maryland | NA | Ba1+ | TIP CODE | | La orus | LIMITS? |
| 1 | ERAL | TO THE STREET AND MUMBER | oldspring! | Lane | 2123 | 9 | 109. CITIZEN | SA |
| g DR | BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S., FORCES? 1 YES IF YES, GIVE WAR OR DATES | ABMED 13. WAS DECI | city Cuben, Mexican | C ORIGIN? (Specify , Puerto Ricen, etc.) | Yes or No — 14. | RACE — American Indian, Black, White, etc. Specify: Black |
| r after | 0 | 15. DECEDENT'S EDUC. (Specify only highest grade of | | DECEDENT'S USUAL OCCUPATIO (Give kind of work done during mos | | 16b. KIND OF I | BUSINESS/INDUS | TRY |
| D 21 spital or ed for u | IPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | TEE Worker | | Beth | lehen | n Steel |
| S Se B | COMPL | 17. FATHER'S NAME (First, Middle, Last) | C S | | 18. MOTHER'S NAM | NE (First, Middle, Majo | iams | |
| MARYI retained by 5 should be notified at | BE | 190, INFORMANT'S NAME (Type/Print) | mes | 19b. MAILING ADDRESS (Street a | Number or Rural R | dute Number, City or | own, State, Zip Co | 00) 2418 , |
| 5 5 5 | 2 | SHERMAN 1- | laukins ! | 3036 Cui 21 | HUYD HU | 5 3 | isaltir | nore, Maryla |
| 6 ma stor, p | | 20e. METNOD OF DISPOSITION 1 Buriel 2 | zel from State | cremetory or other place) | metres | 9-5-75 | BOU | times ned |
| ALTIM death. Page tuneral direct. | | 21. SIGNATURE OF JUNERAL SERVICE LICE | dage | | D ADDRESS OF FAC | OVEZTUE | Reis7 | Erstown Rel |
| | | * Therey 9 | berin | CHA | Tran-L | lams F. | 4. Bak | FINORE, Rd 2121 |
| in by remi | | 23. PART L. Enter the diseases, or co shock, or heart fellure. L | omplications that caused tha lat only ona ceuse on each il | death. Do not enter the mo- line. | da of dyling, such | aa cardiac or re | epiratory arrest | Interval Between |
| he fille | | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Atheroscle | ruhe lard | Duasci. | Mar o | Lizeas | Onset and Death |
| D 0 - 5 | | reauting in death) | DUE TO (OR AS A CON | | | | | |
| Secuendand and bur hadio | NOI | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONS | SEOUENCE OF): | | | | |
| BOX ficate be physician ne prior to | RTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or in)ury | DUE TO (OR AS A CON: | acourac op | | | | |
| Certification and Hygie | | that initiated events resulting in death) LAST | DUE TO (OH AS A CON | SECUENCE OF): | | | | |
| 0 0 0 5 | CE | PART II. Other significant conditions | contributing to death but no | ot resulting in the underlying | csusa given in | Part I. 24a. WAS | AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| - 50 - | ICAL | | | | | PERI | FORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| RECOR w requires that s been signed by ptr. of Health an 3 shows any | MEDIC | | | | | | , | 1 TYES 2 NO |
| Sept as t | | DID TOBACCO USE CONTR | | EATH YES NO L | UNCERTAIN | 1 🗆 | | |
| 一年 書 書 | SICIAN: | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatient | OTHER: | e 5 TResidence | 8 Other (Specify) | | |
| OF VI PHYSICIAN: this certifies with the St | РНҮ | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 28c, INJ | - 43 | 28d. DESCRIBE HO | W INJURY OCCUP | RED |
| ON OD DING PHYS After this death with smarked | ВУ | 1 Netural 5 Pending 2 Accident Investigation | 200 DI ACE OS IN HIDY AL | t home, farm, street, factory, office | YES 2 NO | 201 LOCATION (Su | not and Mumber or | Drivel Davida Mismbas |
| TTEN TOR: after | TED | 3 Suicide 8 Could not be 4 Homicide determined | building, etc. (Specify) | t nome, term, errest, rectory, office | | 281. LOCATION (Stre City or Town, St | | nute number, |
| DIV OR A DIRECT DIRECT Phours | 쁘 | 29e. CERTIFIER 1 CERTIFYING PNYSIC | RAN: To the best of my knowledge, | , death occurred at the time, date | end place, end due | to the cause(s) and | menner ee stated. | |
| TO THE HOSPITAL TO THE FUNERAL (be filed within 72 h | COMPLE | one) 2X MEDICAL EXAMINER | t: On the basis of examination end | l/or investigation, in my opinion, d | eath occured at the | time, date end place | , end due to the o | euse(s) end menner es stated. |
| THE HI Filed w | BE (| 29b, SIGNATURE AND WILE OF CERTIFIER | 4941 | | 29c. LICENSE NUN | | . | IGNED (Month, Day, Year) |
| 2 2 3 | 5 | 30, NAME AND ADDRESS OF PERSON WHO | | | O.C.M | | | GUST 30.1995 |
| 1 | | Varid R Fa | 47 42 | 11 Penn Str | eet, Ba | ltimore | , Mary | land 21201 |
| | | 31. DATE FILED (NOTE POY 101) 1 199 | 5 32. REGISTRARS SIGNATUR | Randall | | | | |

BALTIMORE, MARYLAND 21215-0020

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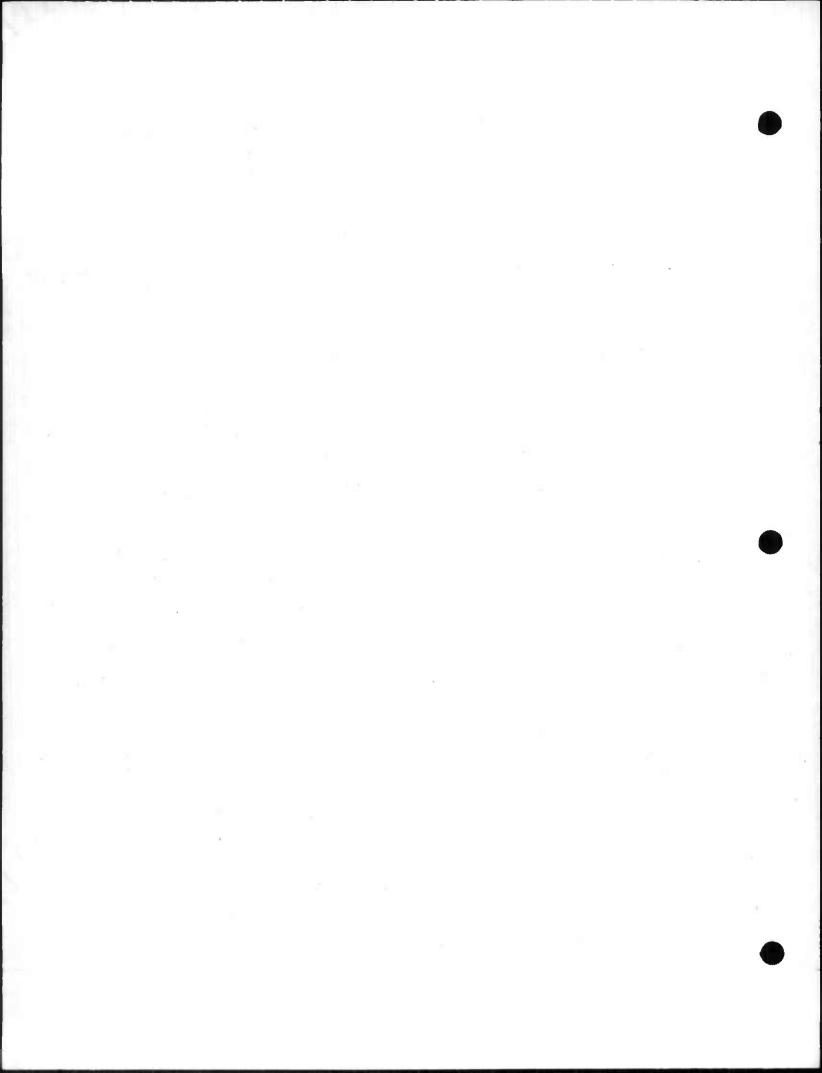
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1 1995

32. REGISTRAR'S SIGN

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH _ MONTH 3. TIME OF DEATH JOHNSON 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State land permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR timore RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION Od. INSIDE CITY more YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5 212 funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yea, specify Cuben, Mexican, Puerto Rican, atc.) 12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS RACE — American Indian, Black, White, atc. If yes, specify Cube 2 Merried 8 Specify: 4 Divorced black COMPLETED 15. DECEDENT'S EDUCATION eclly only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ve kind of work done Do NOT use retired.) College (1-4 or 5+) 18. MOTHER'S NAME (First, Midde NO 24H notified at 6 BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Fig. 21206 2 Marylan HUE TYUYE pe METHOD OF DISPOSITION must Burial 2 Cremation 3 Removal from State Memorial nation 5 Other (Specify) medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LIQUIN PAMO completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode Approximate Interval Between Onset and Death shock, or heart fellure. List only one cause Hygiene prior to burial, cremation, or IMMEDIATE CAUSE (Finel the disease or condition_ resulting in death) traumatic event. executed CERTIFICATION and Sequentially list conditions. if sny, leading to immediate attending physician X cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE that initiated events resulting in death) LAST 0 Courn signed by the atte PART II. Other significant conditions contributing to death but not resulting in the PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO peen 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO L UNCERTAIN Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State this certificate HOSPITAL: DNO OTHER: 1 TES Z Inpetient 2 - ER/Outpetient 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 3 DOA 10 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with marked. 1 Natural TO THE HOSPITAL DR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filled within 72 hours after death w IMPORTANT: If Nem 28 is mark BY 1 YES 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 290. CERTIFIER 29b. SIGNATURE AND TYTLE OF CH 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mgnth, Day, Year) D10152 2 30. NAME AND ADDRESS OF PERSON

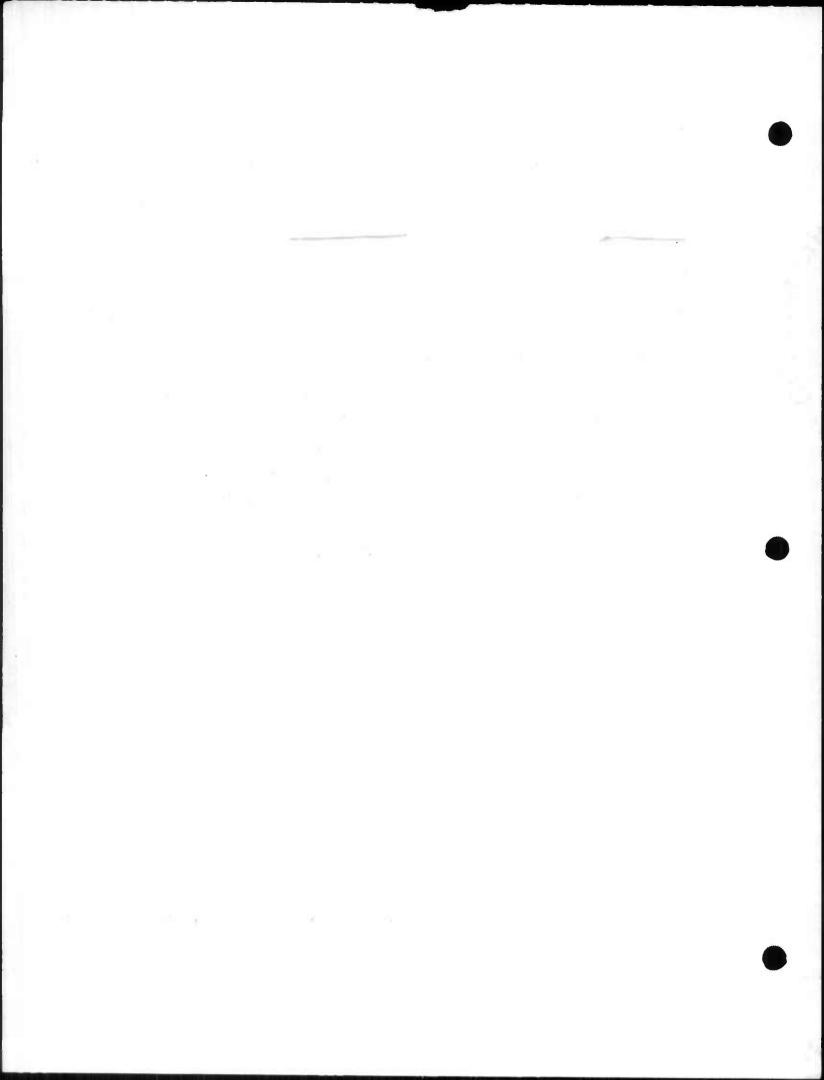
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



| after death. Page 6 may be retained by the hospital or attending physician. | y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | noval. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physic | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacted for use as the burial-transit permit. Pages 1, 2, 3 sho | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |

| | FilmG, 727, for 1- STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR CERTIFI | TMENT OF H | EALTH | ÄND I | MENTAL HYGIEN REG. NO. | E | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | GEORGE | | | JOY | NES | SI | PTEMBER [™] | 7, 1995 | 8:28 A _M |
| | 4. SOCIAL SECURITY NUMBER 5 | 5. SEX 8. AGE (In | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER | | 7. DATE OF BIRTH | 8. BIRTH Countr | PLACE (State or Foreign |
| | 705-09-3718 | 1 M 2 - F 8 | YRS. | MONTHS DAYS | HOURS | MIN. | Gragh, Day Mari | 19 1 | rornin |
| | 9e. FACILITY NAME (If not institution, give stree | at and number) | | 9b. CITY, TOWN C | R LOCATI | ON OF DE | ATH | 9c. COUNTY DF D | EATH |
| DIRECTOR | 2404 REISTERSTO | OWN ROAD | | BALTI | MOR | Ε | | N | A |
| HE | NEW YORK 106. COUNTY | 1111 | 10c. CITY | TOWN DR LOCAT | IDN | | YONKERS | | 10d. INSIDE CITY |
| | marytane | VIH | 16 | PAHIA | 2000 | 2 | TONKERD | | 1 YES 2 ND |
| FUNERAL | 10s. STREET-AND NUMBER | / | | 101 | ZIP COD | 2.0 | | 10g. CITIZEN OF V | VHAT COUNTBY? |
| 当 | 115 PARK HU | e, | | | 107 | 03 | | UI | 51/11 |
| 2 | 11. MAJUTAL STATUS 1 1 Never Narried 2 Merried | | 2 NO | If yes, sp | ecify Cuba | n, Mexica | iiC DRIGIN? (Specify Yea n, Puerto Rican, etc.) | or No- 14. RACI | E — American Indian, t, White, atc. |
| B≺ | 3 X Widowed 4 Divorced | IF YES, GIVE WAR DR DAT | ES 1 | t 🗌 YES | 2 ND | Specify | <i>f</i> : | Spec | /nat |
| | 15. DECEDENT'S EDUCAT | | 16a. DECEDENT'S | USUAL OCCUPATION | ON | | 16b. KIND OF BUS | SINESS/INDUSTRY | |
| COMPLETED | (Specify only highest grade co. | College (1-4 or 5+) | (Give kind of v | vork done during mo protired.) | ist of working | 19 | | | |
| 기로 | 9 | 0 | B+01 | Yailro. | Ad 1 | 20-To | estate 41 | V, V | |
| S S | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOT | HER'S NA | ME (First, Middle, Maiden | Surgeryli | |
| 111 | | | UNK | nousy | 5 | Ad | e. (0) | lins | |
| TO BE | 19a, INFORMANT'S NAME (Type/Print) | 11 | 19b. MAILING | ADDRESS (Street | and Number | or Rural | Route Number, City or Tow | n, State, Zip Code) | |
| | Gloria Dowel | 9 | 7404 | Keisler | 5/00 | WK | Cl. BAI | morell | 1 01217 |
| | 20a. M5THDD OF DISPOSITION 1 D Burial 2 Cremetion 3 Remove | | LACEAND DATE | OF DISPOSITION (Na ther place) | ament | | 90 E 20c. LO | CATION — City or To | own, State |
| | 4 Donation 5 Other (Specify) | | 11.2 | 10n | M | n | 111 1 61 | 4110. Co | , 7/1d, |
| CYPHILL | 21. SIGNATURE OF FUNERAL SERVICE LICEN | 1 D | | DSC | 077 | . R | USS PUN | ermi | ome |
| | a seple of | , Russ | | 200 | 20, | NO | -Th Ave, | BAllin | nove/12,2121 |
| III. | 23. PARY i. Entar the diseases, or con shock, or heart failure. Lie | | | not anter the mo | de of dy | ing, suc | h aa cardiac or reap | iretory arreat, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final | at Dilly one occor on acc | | | | | | | Onset and Death |
| 1, 196 | disease or condition resulting in death) | Arteriosc | leroti | c Card | iova | scu | lar Disea | ase | |
| EVEIII, | | DUE TO (DR AS A C | CONSEQUENCE D | F): | | | | | |
| NO | Sequentially list conditions, b. | DUE TO (OR AS A C | CONSEQUENCE OF | F). | | | | | |
| ATION | if any, leading to immediata cause. Entar UNDERLYING | DOE TO (OII NO N | JOHOLO GLIVOL D | | | | | | |
| TIFIC | CAUSE (Disessa or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | |
| 5 5 | PART if. Other algnificant conditions | | | | | | | | |
| = - | | | | le Aberrale de le | | olean In | Don't as unnas | ALITHODON DAY | WERE AUTOROU PRIORITION |
| | | contributing to death bu | t not reaulting | in the underlyin | g cause | givan in | PERFO | RMED? | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DE CAURE |
| | | contributing to death bu | t not reaulting | in the underlyin | g cause | givan in | | RMED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020
after death, Page 6 may be retained by the hospital or attending physician.
y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the study within 72 hours after death with the State Debt, of Health and Mental Hydeline prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| TO THE H | THE F | IMPORT | |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

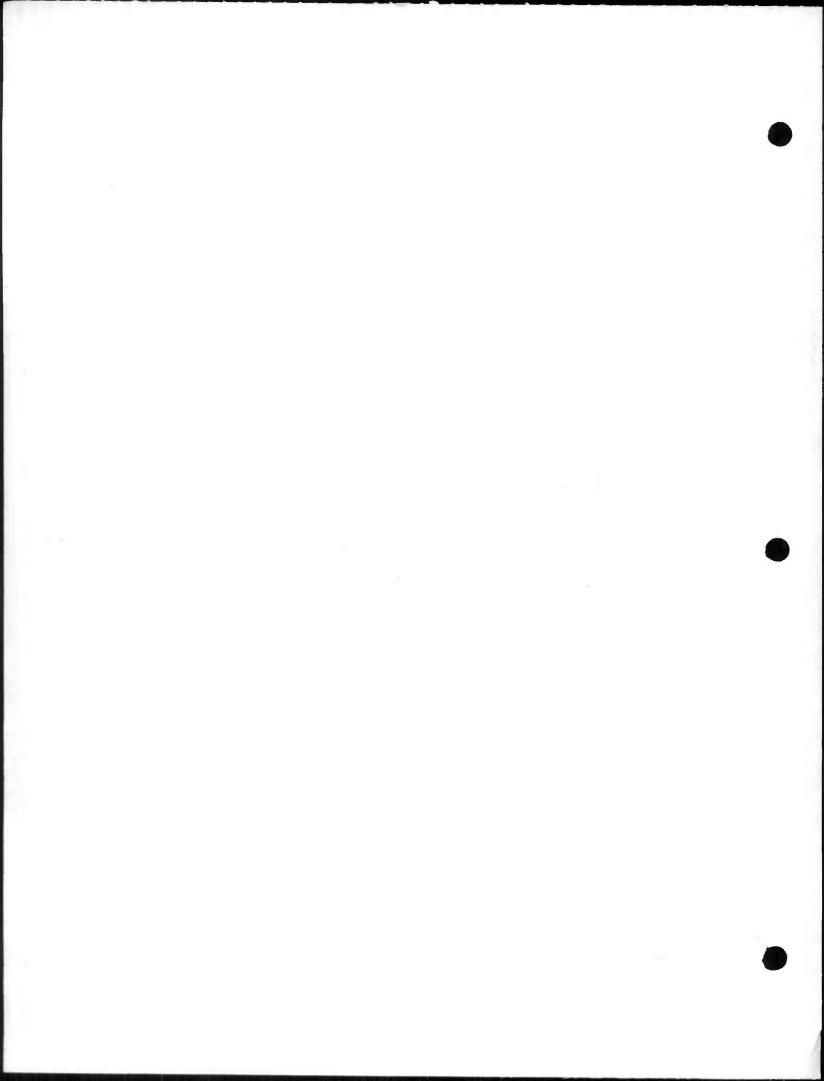
CERTIFICATE OF DEATH

ECCEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH

| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE | OF DEATH | | | 3. TIME OF DEATH |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------|-----------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|-------------|-----------------------------------------------|-------------------------------|-----------------------------------|------------------|------------------------------------------------|
| | ROBERT | | W. 1 111000 A 1 | 4518 | SEPT D | | | | | 7 95 /232 PM 8. BIRTHPLACE (State or Foreign | | | | |
| | 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. II) $X^{M-2} \Box F$ 6. AGE (In yrs. II) $X^{M-2} \Box F$ 76 | | | | | WONTHS E | DAYS | HOURS | 0.0001 | (Month | , Day, Yearl | ry) | | |
| | 90. FACILITY NAME (If not in | | | 76 | 11101 | AP CITY T | OWAY O | R LOCATI | | | 31, 19 | | Mar INTY OF D | ryland |
| OR | St. Agnes Hospital | | | | | | | | | | | | /A | PEA(II) |
| 5 | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | | | 10c CITY | TOWN OR | LOCAT | ION | | | | | | 10d, INSIDE CITY |
| DIRECTOR | Maryland | Ba1 | timore | | 100. 011 | TOWN ON | LOUNI | | aton | svil | le | | | LIMITS? |
| FUNERAL | 10a. Street and Number 213 Kenwood Avenue | | | | | | 101. ZIP CODE 21228 | | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 5 | 11. MARITAL STATUS | | | IT EVER IN U.S. AR | | | | | | | ? (Specify Yes | or No- | 14. RAC | E — American Indian, k, White, stc. |
| | 1 Never Merried 2 | | IF YES, GIVE Y | X YES 2 1 | 10 | | | 2 NO | | n, Puerto R y: | lican, etc.) | | Spec | Mv. |
| ВУ | 3 🔀 Widowed 4 🗌 Divo | reed | WW I | | | | | | | | | | | White |
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| ₹ | | | | Auto | o Mec | nanic | | | _ | | wner/S | | Emp L | oyed |
| 8 | 17. FATHER'S NAME (First, M | | oursey Ki | aa ba | | | | 18. MOT | HER'S NA | | Aiddle, Meiden | | | |
| BE | 190, INFORMANT'S NAME (I | | Jursey K | | | | | | | | se Mir | | | chell |
| 12 | Mary Elizah | | rebs | | | | | | | | lle, M | | | |
| | 20e. METHOD OF DISPOSIT 1X Buriel 2 Cremetic 4 Donation 6 Other | on 3 🗆 Rem | ovel from State | 206. PLACE | AND DATE O | F DISPOSITION PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERT | ON (Na | me of | 11/9 | OATE | | tonsville, MD | | |
| | 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE M | de | | 22. N/ | ME AN | ID ADDRE | SS OF FA | CILITY | | | V 1 11 | COLID |
| MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 2122 | | | | | | | | 21228 | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (FI | | | | | AT11(n) | +- | | | | | | | Onset and Death |
| | disease or condition resulting in death) | → | CONRES! | IVE HEA | ILI T. | ALLVII | t | | | | | | | 10 DAYS |
| | | | DUE TO | OR AS A CONSE | OUENCE OF |): | | | | | | _ | | |
| Z | Sequentially list conditions, Out TO (OR AS A CONSEQUENCE OF). | | | | | | | | | | | | | |
| Ĕ | If any, leading to immediate | | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Inju | | C. DHE TO | OR AS A CONSE | OUENCE OF | ١. | | | | | | | | |
| E | that initiated aventa resulting in death) LAS | т | 002 10 | (On AS A CONSE | OUENCE OF |); | | | | | | | | |
| 5 | | | d | | | | | | | | | | | |
| | PART II. Other significa | ent condition | na contributing to | deeth but not | reaulting is | n the und | arlying | cause | given in | Part I. | 24a. WAS AN | | 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICAL | | | | | | | | | | | | NO | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | 0 | | 1 YES 2 NO |
| 2 | DID TOBACCO U | ISE CONT | RIBUTE TO CA | AUSE OF DEA | TH YE | S 🗆 N | 0 2 | UN | CERTAI | N 🗆 | | | | |
| NA I | 25. WAS CASE REFERRED T | O MEDICAL | | 26. PLA | CE OF DEAT | | ly one) | | | | | | | |
| SIC | EXAMINER? | | HOSPITAL: 1 Pinpetlent 2 | ☐ ER/Outpetient 3 | DOA | OTHER: 4 Nursin | ng Hom | • 5 🗆 R | lesidence | 8 🗆 Othe | r (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 28e. OATE O | F INJURY Day Year) | 28b. TIME | | Sc. iNJ | URY AT | | 28d. DES | ESCRIBE HOW INJURY OCCURED | | | |
| Netural 5 Pending (Month, Day, Year) INJURY WORK? 1 YES 2 NO 20 Pacident Investigation | | | | | | | | | | | | | | |
| ED B | a D suiside | Could not be | | OF INJURY — At he | ome, ferm, s | treet, fector | y, offic | 0 | | 26f. LOC | ATION (Street or Town, State) | and Numbe | er or Runsi | Route Number, |
| E | 4 Homicide | determined | | , , , , , , , , , , , , , , , , , | | | | | | | , , , , , , , , , , , , | | | |
| COMPLET | 200. CERTIFIER 1 CER | TIFYING PHYS | ICIAN: To the best of | if my knowledge, de | esth occurre | d at the tim | e, date | and plac | e, end du | e to the cau | use(e) and mar | nner ee st | sted. | |
| ME | (Check only one) 2 MEC | ICAL EXAMINI | ER: On the beele of | examination end/or | Investigation | n, In my opi | inlon, d | lesth occu | ared at the | time, date | end place, en | d due to | the cause | (e) and menner as stated. |
| | 29b. SIGNATURE AND TITLE | E OF CERTUFIE | B) 1 | | | | | 29c. LIC | ENSE NU | MBER | | 29d. DA | TE SIGNE | D (Month, Day, Year) |
| BE | IMA | (1)4 | netilik | , | | | | P | 0821 | | | | | 18ER 7, 1995 |
| 2 | 30. NAME AND AODRESS O | F PERSON WI | O COMPLETED CAI | JSE OF DEATH (ITE | M 27) (Type. | Print) | | <u>'</u> | | | | | | |
| | VJPUT | | WILLALL | | MEN | | SPIT | AL | Λ | MITTO | MINE | MAR | LYLAN | 1). |
| | 31. DATE FILEO (Month, Day, | -9 | • | | 110-11 | , (0 | D1.1 | | *,) | 11010 | | - | | • |
| | | 395 | 32. REGISTA | workerdall | | | | | | | | | | |
| | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | 0 | | | | | | | | | | | | DUMM.16 Gay 1/80 |





TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAR | | CERTIF | ICALE | JF DEAL | I H | REG. NO. | | | | |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------|---------------------------------------------|--------------------|-----------|-----------------------------------------------------|-------------------------------------|--------------|-------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | 2. DATE OF DEATH | 50 | WEAR | 3. TIME OF DEATN | |
| | Evelyn M. Kapı | raun | | | | | | 995 | YEAR | 9:30pm M | |
| - 1 | | | AGE (In yrs. lest birthday) | IF UNDER 1 Y | EAR IF UNDER | 24 HRS. | 7. DATE OF BIRTH | 793 | S. BIRTN | PLACE (State or Foreign | |
| - 1 | | | | | YS HOURS | MIN. | (Month, Day, Year) | _ | Country | y) | |
| | 213 12 3303 | □ M 2 F | 75 YHS. | | | | Aug 9, 192 | | | ryland | |
| - 1 | 9a. FACILITY NAME (If not institution, give street | t and number) | | 9b. CITY, TO | WN OR LOCATIO | ON OF DE | EATN | 9c. COUN | NTY OF D | EATN | |
| 8 | 405 Kilree Ro | oad | | Tin | onium | | | Balt | timo | re | |
| | RESIDENCE OF DECEDENT | | | | | | | | | | |
| Ĭ Ĭ | 10a. STATE 10b. COUNTY | | 10c. Cl | TY, TOWN OR L | OCATION | | | | | 10d. INSIDE CITY LIMITS? | |
| 5 | Maryland Baltin | nore | Ti | monium | 1 | | | | | 1 YES 27 NO | |
| | 10e. STREET AND NUMBER | | | MOIII GII | 10f. ZIP CODE | F. | | ina CITI | ZEN OF Y | VHAT COUNTRY? | |
| FUNERAL | | | | | 1011 211 0000 | | | | | | |
| 單 | 405 Kilree Roa | ad | | | | 21 | 093 | U.S | 5.A. | | |
| 5 | | 2. WAS DECEDENT EV FORCES? 1 1 | | | | | NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) | or No- | 14. RACE | - American Indien, t, Whita, atc. | |
| | 1 Never Married 2 Married | IF YES, GIVE WAR | | | YES 2 NO | | | | Specif | | |
| B | 3 Widowed 4 Divorced | | | | X | | | | | White | |
| | 15. DECEDENT'S EDUCAT | TION | 16a, DECEDENT'S | USUAL OCCL | PATION | | 16b. KIND OF BUS | INESS/IND | USTRY | | |
| ĔΙ | (Specify only highest grade cor | | (Give kind of life. Do NOT u | work done durii ise retired.) | ng most of working | פר | | | | | |
| اچ | Elementary/Secondary (0-t2) | College (1-4 or 5+) | Homemake | 10 | | | 0 | Home | | - 1 | |
| 2 | | | пошешаке | L | | | | | 4 | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | te. MOTI | NER'S NA | ME (First, Middle, Meiden | Sumame) | | | |
| BE | George D. Miller | | | | Ab1 | by T | owson | | | | |
| - | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILIN | G ADDRESS (S | treet and Number | or Rural | Route Number, City or Town | n, State, Zip | Code) | | |
| 2 | Carl Kapraun | | 221 P | a rkwoo | d Road | D11 | nkalk, Mar | vland | 1 211 | 222 | |
| | 20a. METNOD OF DISPOSITION | | _ | | | Du | | CATION - | | | |
| | 1 ☐ Burial 2√XCremation 3 ☐ Remove | I from State | 20b, PLACE AND DATE cemetery, cramatory or | other place! | | | | | | | |
| | 4 Densition 5 Other (Specify) Green Mount Cemetery 9/11/95 Baltimore, Marvland | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz, JR. Funeral Home | | | | | | | | | | |
| | 16 600 | No. t | | 3818 Roland Ave., Batlimore, Maryland 21211 | | | | | | | |
| | 23. PART i. Enter the diseasea, or con | Dec 16 | n | | | | | | | ryland ZIZII | |
| IEDICAL CERTIFICATION | disease or condition resulting in death) a. Moderation and a consequence of: Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 24a. Was an autopsy finding analytic program of the underlying cause given in Part i. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of cause of peather of the underlying cause given in Part i. PART II. Other significent conditions contribution of the underlying cause given in Part i. PART II. Other significant conditions contribution of the underlying cause given in Part i. | | | | | | | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| 2 | DID TODA COO LICE CONTINU | DUITE TO CALIC | F OF DEATH V | PR P 1 1/4 | | CEDTAL | NI ET | | - 1 | 1 1 1ES 2 NO | |
| PHYSICIAN: | DID TOBACCO USE CONTRII | BUIL IO CAUS | | 7 | | CERTAI | и П | | | | |
| CI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF OE | OTHER: | r one) | | | | | | |
| S | _ / | | /Outpatient 3 🗆 DOA | | Home 5 R | asidenca | 6 Other (Specify) | | | | |
| Ŧ | 27. MANNER OF DEATH | 28a. DATE OF INJ | | | c. INJURY AT | | 28d. DESCRIBE NOW I | NJURY OC | CUREO | | |
| | Netural 5 Pending | (Month, Day, Y | bar) | IJURY M | WORK? | NO | | | | | |
| BY | 2 Accident Investigation | 28° BI ACE OF IN | JURY — At home, ferm | eteral factors | | | 201 I OCATION (Steel | et and Number or Rural Route Number | | | |
| | 3 Suicide 6 Could not be 4 Nomicide determined | building, atc. | | , street, ractory | , omce | | City or Town, State) | | OF PILITEE I | riodie Number, | |
| E | 4 Nomicide determined | | | | | | | | | | |
| 7 | 29a. CERTIFIER CERTIFYINO PHYSICIA | AN: To the best of my | knowledga, death occu | rred at the time | , dete and place | a, and du | e to the cause(a) and me | nner es ste | ted. | | |
| 3 | (Check only one) 2 MEDICAL EXAMINER: | _ | | | | | | | | a) and manner as stated. | |
| COMPL | 0.7 | | | ,, ., | | | | | | , | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 72 | 2 | | 29c. LIC | ENSE NU | MBER | 29d. DAT | E SIGNED | (Month, gay, Year) | |
| 8 | TITYUKKU | 1003 | | | 1 | 36 | 5814 | | 4/1 | 1/45 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE C | F DEATH (ITEM 27) (Tyr | e, Print) | | | - 1 | | 1 | 1 | |
| | BICHARD | L, +/1 | 15/19 7 | 505 | 05/6 | ER | Dr. Soin | ES | ,04 | Towson | |
| | ST. DATE FILED (Month, Day, Year) SE-D 1 1 1005 | 32. REGISTRAR'S | SIGNATURE | | | | | | | | |

| 1 | | FOR STATE REGISTRAR |
|---|------|---------------------------|
| | 1. D | ECEDENT'S NA |

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-728 10/25/95 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | Ci | EKIIFI | CALE | OF | DEAL | н | | REG. NO. | | | |
|---------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------|------------|---------------|----------------|---------------------|-------------|--------------------|---------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF MONTH | DEATH | | YEAR | 3. TIME OF DEATH |
| | DIANE T | ENTSE | | LA | WS | | | | SEP | | | 95 | 1:58 P. M |
| | 4. SOCIAL SECURITY NUMBER | | S. AGE (In yrs. In: | st birthday) | IF UNDER 1 Y | EAR | IF UNDER | 24 HRS. | 7. DATE OF | BIRTH | | B. BIRTH | PLACE (State or Foreign |
| | 214-68-4850 | 38 | YRS. | MONTHS DAYS HOURS MIN. (Month, Day, Year) NOV 11 / 1956 | | | | | | Country | " Md | | |
| | 9e, FACILITY NAME (If not institution, give st | 1 M 2 F | | | 9b. CITY, TO | O MWC | R LOCATIO | N OF DE | | alla vilo (| | NTY OF DI | |
| œ | | 2.1-2.17.74 | | | | | | | | | | | |
| DIRECTOR | 5527 CADILLAC | AVE. | | | BALTIMORE | | | | | | | | |
| E | 10e. STATE 10b. COUNTY | , | | 10c. CITY, | TOWN OR I | LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| E | ма | N/A | | Bal | timo | re | | | | | | | t X YES 2 NO |
| | 10e. STREET AND NUMBER | | Dur | CIMO | _ | ZIP CODE | | | | 10g. CITI | ZEN OF W | THAT COUNTRY? | |
| FUNERAL | 5527 Cadillac | | | | 2120 | 7 | | | U | SA | | | |
| Z I | 11. MARITAL STATUS | RMED | 12 WB | _ | | _ | IC ORIGIN? (| Specify Yes | | | - American Indian. | | |
| | 1 Never Married 2 Merried | NO | If y | es, spi | cify Cuber | n, Mexican | n, Puerto Ric | | G. 110 | Black | , White, etc. | | |
| ВУ | 3 Widowed 4 Divorced | | 1 | TES | 2 X NO | Specify. | | | | Spech | Black | | |
| 0 | 15. DECEDENT'S EDUC | CATION | 16e. DI | ECEDENT'S U | SUAL OCCI | UPATIO | N . | | 16b, K | IND OF BUS | SINESS/IND | USTRY | 2 |
| | (Specify only highest grade Elementary/Secondary (0-12) | Completed) College (1-4 or 5 +) | ine | Bive kind of wo a. Do NOT use | ork done duri retired.) | ing mo | st of working | g | | | | | 2.1 |
| P | 12th grade | | Nurs | e I. | Р | . N | | | Nurs | ina | Hom | 6 | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | HULD | 0 2. | | | | ME (First, Mid | | | | | |
| | Nathaniel W. | Barbar | | | | | Ma | ria | n H | onki | ng | | 1.0 |
| BE | 19a, INFORMANT'S NAME (Type/Print) | Barber | 16 | b. MAILING / | ADDRESS (S | Street a | | | - | | | Code) | |
| 2 | Willie Green | | | | | | | | 3 enue | | | | 21207 |
| | | | 20h PLACE | 5527 | | _ | | AV | DATE | | CATION - | | |
| | 20a METHOD OF DISPOSITION t Burlet 2 Cremetion 3 Remote 4 Donation 5 Other (Specify) | | Tawn | | | | | 91195 | | ltin | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | A = G W 11 | 22. NAME AND ADDRESS OF FACILITY | | | | | | | , | | | |
| | - la | | 2 | | I | Man | in F | /H 1 | West | | | | |
| | Nady | War | لبعد | | 43 | 300 | Wak | sah | Avenu | ie B | altin | nore | Md 21215 |
| | 23. PART I. Enter the diseases, or c | | | | ot enter th | a mo | de of dyl | ng, such | h aa cardla | c or reapl | ratory an | reet, | Approximate Interval Between |
| | | | | | | | | | | | Onset and Death | | |
| | dlease or condition PROPOXYPHENE INTOXICATION | | | | | | | | | | | | |
| | reauting in death) | DUE TO (| OR AS A CONSE | OUENCE OF |): | | | | | | | | |
| Z | | 6 | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| SAT | csuse. Enter UNDERLYING | | | | | | | | | | | | |
| Ĭ | CAUSE (Disease or Injury that Initiated events | DUE TO (| OR AS A CONSE | OUENCE OF | 5): | | | | | | | | |
| F | resulting in death) LAST | d | | | | | | | | | N | | |
| C | DART II Oak on also Misson and distant | a consultration to | de adle level and | | 46 | of to | | de constant | Deat I | 4a. WAS AN | | | |
| EDICAL | PART II. Other significant condition | s contributing to c | aath but not | resulting in | tha unde | errying | g cause g | given in | Part I. 2 | PERFOR | | 246 | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| DIC | | | | | | | | | _ 1 | ES 2 | □ NO | | OF DEATH? |
| ME | | | | | | | | | [(| | | | 1 TES 2 NO |
| | DID TOBACCO USE CONT | RIBUTE TO CAU | JSE OF DE | ATH YES | S N | 0 [| UNC | ERTAIN | 1 🗆 | | | | |
| SIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 1 26. PLA | CE OF DEATI | | ly one) | | | | | | | |
| PHYSICIAN: | 1 XYES 2 NO | 1 Inpetient 2 | ER/Outpetient | OTHER: 4 □ Nursing Home 5 X Residence 6 | | | | | 6 ☐ Other (Specify) | | | | |
| Ť | 27. MANNER OF DEATH | 26e. DATE OF I | NJURY V Meer) | FOUNE | OF 2 | 6c. INJ | URY AT | | 26d. OESC | RIBE HOW I | NJURY OC | CURED | |
| ВУР | 1 Netural 5 Pending 2 Accident Investigation | FOUND: 9 | - ' | 1:50 | | 1 🔲 | | ON [| SUBJEC | T INGE | STED | DRUG | |
| | 3 XXSuicide 6 Could not be | | INJURY - At h | ome, ferm, st | treet, factor | y, offic | • | | 261. LOCAT | ION (Street | end Number | or Rural F | LLAC AVE. |
| TED | 4 Homicide determined | Montalda data with a building, stc. (Specify) | | | | | Ē | | BALTIM | | | CADI | LLAC AVE. |
| LET | 290. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of r | ny knowledne d | leath occurre | d at the time | o date | and place | and due | to the cause | (a) and ma | nner ee sta | ted. | |
| COMPL | (Check only one) 2 MEDICAL EXAMINE | and the same of the | orazona i al Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Caracia de la Car | | | | | | | | | | e) end menner ee stated. |
| 8 | | | , | 0 53505 | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | 11/ | / | | | | | C.M | | | | PT. | (Month, Day, Year) 7, 1995 |
| 5 | 30, MAIRE AND ADDRESS OF PERSON WH | 10/200 | No. | Par on o | (Parl - A) | | 0. | 0.11 | • • | | 101 | | , , 1000 |
| | , | | | | | +- | eet | Ra | 1 tim | ore | Mar | arlar | nd 21201 |
| | THE MORE M | | | ı re | 1111 3 | CI | CCL, | Da | A CAIII | ore, | Hall | ула | 114 21201 |
| | 31. DATE FILED (Month, Day, Year) | 3 REGISTRAF | S SIUNATURE | 1.11 | | | | | | | | | |
| | GED1 1 1995 | LALUA OUR | MANUAL LAND | Artist . | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

OHMH-16 Rev 1/89

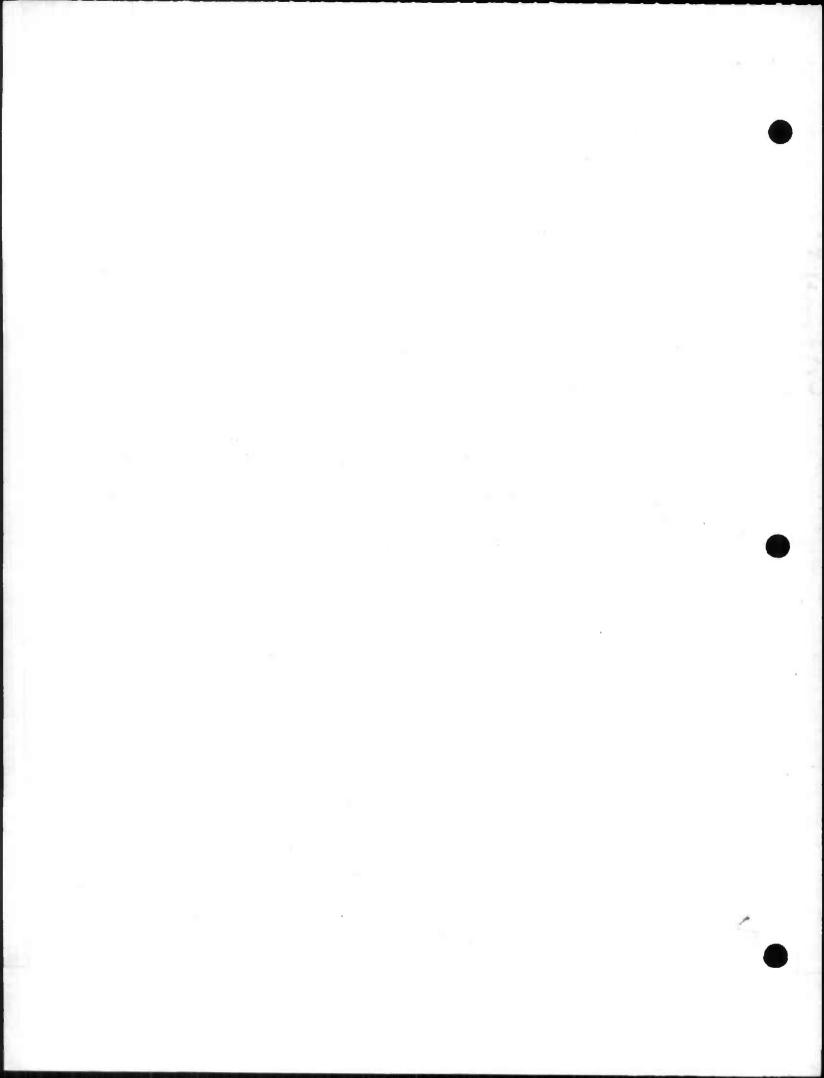
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

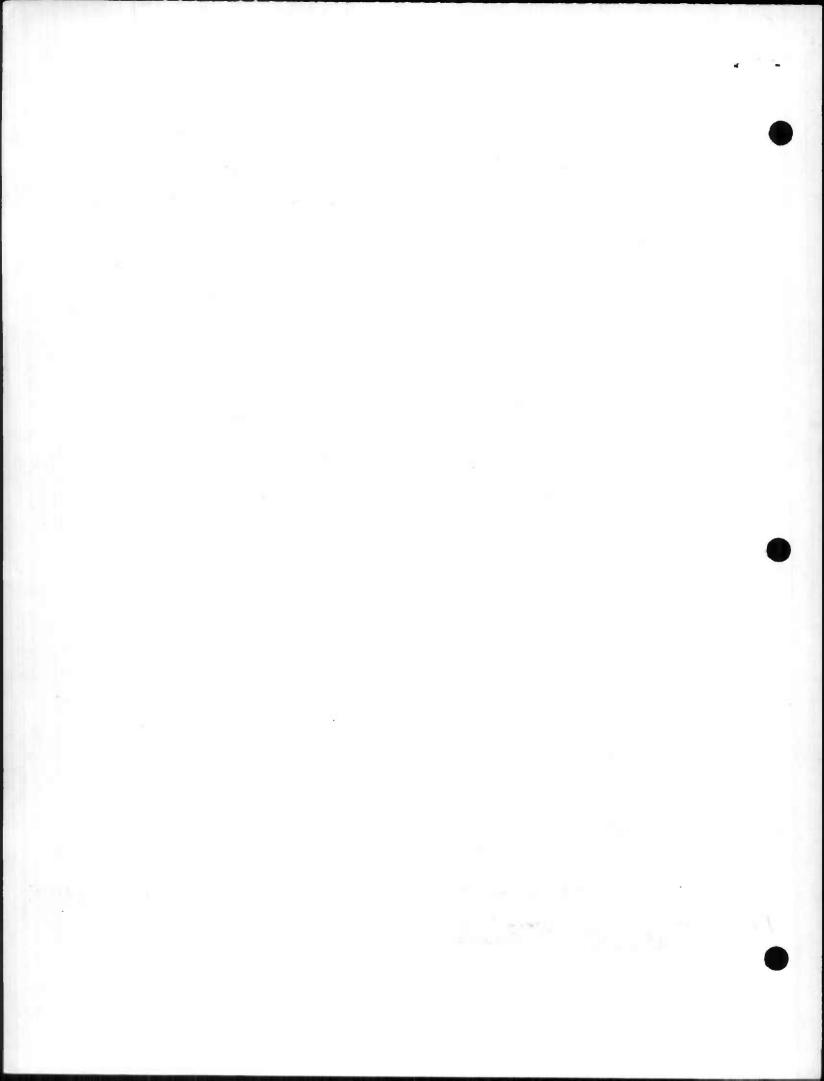
| | REGISTRAR | | C | ERTIFIC | ATE OF | DEATH | | REG. NO. | | |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------|-----------------------|--------------------|----------------------------------------|--------------|------------------|-------------------|-------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE C | F DEATH | | 3. TIME OF OEATH |
| | | r white | T 171 | D | | | MONTH | DA | | AR |
| | BARBRA 4. SOCIAL SECURITY NUMBER | T T I V I V | LE! | | e Indeed a serie | T manufacture | AUG | | 1995 | 111:15 P.M |
| | SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Ia: | M | DNTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | (Month, | Day, Year) | C | HRTHPLACE (State or Foreign country) |
| | 218-37-6991 | 1 M 2 F | 2 | YRS. | | | 12- | 31-9 | 2 1 | nAryand |
| | 9a. FACILITY NAME (If not institution, give : | street end number) | | 9 | b. CITY, TOWN | OR LOCATION OF DE | EATH | | 9c. COUNTY | OF DEATH |
| | 2112 DAVED C | m | | | DATME | VODE | | | / | 1//4 |
| | 3112 BAKER S' | | | | BALTI | MORE | | | | 4/11 |
| | 10a. STATE 10b. COUNT | Υ / | | 10c. CITY, | TOWN OR LOCA | TION | | | | 10d. INSIDE CITY |
| 1 | mana ha 1 | 1/10 | | 1 | 2 11 | 15 - | .) | | | LIMITS? |
| | In Prylland | V / /7 | | 100 | 17// | 111000 | | | | 1 X YES 2 NO |
| | 100. STREET AND NUMBER | | 4 | | 10 | H. ZIP CODE | | | 10g. CITIZEN | OF WHAT COUNTRY? |
| | 1111 F 20" | Stree | | | | 2/2/ | P | | 1. | 15,4 |
| | 11. MARITAL STATUS | 12. WAS DECEDENT | | | | CENDENT OF HISPAR | | | or No- 14. | RACE - American Indian, |
| - 1 | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE W | YES 2 X | NO | | pecify Cuben, Mexica S 2 NO Specify | | lcan, atc.) | | Black, White, atc. |
| | 3 Widowed 4 Divorced | IF TES, GIVE W | AN ON DATES | | 1 1 16 | S 2 NO Specing | у: | | | Black |
| | 15. DECEDENT'S EDU | ICATION | 40. 0 | ECEDENTIA III | BUAL OCCUPATI | 101 | 105 | VIND OF BUIL | INESS/INDUST | 3/1400 |
| | (Specify only highest grade | | (0 | Sive kind of wor | k done durina m | | 160. | KIND OF BUS | SINESS/INDUST | HT |
| | Elementary/Secondary (0-12) | College (1-4 or 5 + |) "" | Do NOT year | etired.) | | | | | |
| | | 0 | | OF | 104 | | | | | |
| | 17. FATTIER'S NAME (First, Middle, Last) | | | | / | 16. MOTHER'S NA | ME (First, M | iddle, Maiden | Surname) | 1 1 |
| | Dunht | Lee | | | | An - | cin | 1, | 1 11 11 | lahnens |
| | 19a, INFORMANT'S NAME (Type/Print) | 1 | | M. 84 A 44 Section 11 | DDDEED CO | 1 / // 1S | 3//7 | 24 | n. State. Zip Cod | 10///0040 |
| | 198. INFOHMANT'S NAME (NONPTINE) | | 19 | MAILING A | 7777 | and Number or Rural | rioute Numbi | er, City or low! | n, State, Zip Cod | 1 21212 |
| | Mrs, Parber. | Johnso | 21 | 1112 | 0,0 | reel 0 | 17/17 | more | y The | 1.21218 |
| Ì | 20a. METHOD OF DISPOSITION | | | | DISPOSITION /A | lame of | PATE | 20c. LO | CATION — City | or Town, Stata |
| | 1 Buriel 2 Cremation 3 Ran 4 Donation 5 Other (Specify) | noval from Stata | gentletery, cr | emetory or other | r place) | 100 may ton | 1//11 | B | p/to | now Mod. |
| 1 | II. SIGMATURE OF FUNERAL SERVICE LI | CENSEE | 10/6 | E //rno | | AND ADDRESS OF FA | CHOR | 100 | 7//// | 0/1/20 |
| | The or rollering service of | () | | | 65 | eph L. | RUS | 55 F | UNEr | 11/110me |
| | 16 | 1 V | 111 | | 250 | 5 11 1/2 | the | 1.10 | au It | 6.12111 |
| | 23. PANY I. Enter the diseasea, or | complications that | | anth Do an | 000 | 30,700, | Y/12 F | 10012 | 18/101 | 1110101216 |
| | shock, or heart fallure. | | | | enter the m | oda or dying, suc | n aa caro | ac or respi | ratory arrest, | Approximate interval Batween |
| | IMMEDIATE CAUSE (Final | | | | | | | | | Onset and Death |
| | disease or condition | SULDIA | 5 Dul | h1 , 1 | da | AMT | W all | - A. C | orus | |
| | resulting in death) | | OR AS A CONSE | | 11100 | 1-104 | What I'm | 610 | 20(4) | |
| | | | | , | | | | | | j |
| | Sequentially list conditions, | b | ADD AC A CONIDE | OUENOE OD | | | | | | |
| | if any, laeding to immediate | DUE TO | (OR AS A CONSE | OUENCE OF | | | | | | ì |
| | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | | |
| | that initiated events | DUE TO | (OR AS A CONSE | QUENCE OF): | | | | | | |
| | resulting in death) LAST | 4 | | | | | | | | |
| | | d | | | | | | | | |
| | PART il. Other algnificant conditio | na contributing to | daeth but not | reaulting in | the underlyle | ng cause given in | Part i. | 24s. WAS AN | | 246. WERE AUTOPSY FINDINGS |
| | | | | | | | | PERFOR | . / | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | 1 YES 2 | | OF DEATH? |
| | | | | | | | _ | THE. | arriar | 1 YES 2 NO |
| | DID TOBACCO USE CONT | TRIBUTE TO CA | USE OF DEA | ATH YES | | UNCERTAI | N 🗆 | 2111 | | |
| | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLA | CE OF DEATH | (Check only one |) | | | | |
| | EXAMINER? | HOSPITAL: | 1 | | THER: | | | | | |
| | 1 Dyes 2 No | 1 Inpatient 2 | | 7 | T | me 5 Nesidence | | | | |
| | 27. MANNER OF DEATH | 28a. DATE OF (Month, D | | 28b. TIME INJUI | OF 28c. IF | JURY AT /ORK? | 28d. DES | 4 | NJURY OCCUR | |
| | 1 Netural 5 Pending 2 Accident Investigation | 1 / 21 | 395 | 12215 | 1 I | YES 2 NO | 700 | heat IM | must ? | stoke from Fina |
| | • 🗆 • • • • • • • • • • • • • • • • • • | 26a. PLACE O | F INJURY At h | ome, farm, str | eet, factory, off | Ice | 281. LOCA | ATION (Street I | and Number or F | Bural Route Number, |
| | | building, | atc. (Specify) | 5 | | | City | or Town, State) | ERST V | SAUTHORS MY |
| | 3 Suicide 6 Could not be 4 Homicide datarmined | | 140 | | | | 12113 | 1)/10 | 61034 | SHOWE IN |
| | 4 Homicide datarmined | | | | at the time of the | to and place and dry | to the cau | se(a) and mer | nner as atated. | |
| | 4 Homicide datarmined 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | SICIAN: To the best of | my knowledga, d | leath occurred | at the time, on | te and piece, and do | | | | |
| | 4 Homicide datarmined 29a. CERTIFIER (Check only | | | | | | time, deta | | d dua to the ca | ause(s) and menner as stated. |
| | 4 Homicide determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | IER: On the basis of a | | | | death occured at the | | | | |
| | 4 Homicide datarmined 29a. CERTIFIER (Check only | IER: On the basis of a | | | | death occured at the | MBER | | 29d. DATE SI | GNED (Month, Day, Year) |
| | 4 Homicide determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | IER: On the basis of a | | | | death occured at the | MBER | | | GNED (Month, Day, Year) |
| | 4 Homicide determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | IER: On the basis of a | xamination end/o | r Investigation, | In my opinion, | death occured at the | MBER | | 29d. DATE SI | GNED (Month, Day, Year) |
| DE COMPLEIE | 4 Homicide datarmined 29a. CERTIFIER Check only one) 2 MEDICAL EXAMIN 29d. SIGNATURE AND TITLE OF CERTIFIER | IER: On the basis of a | xamination and/or | r investigation, | In my opinion, | 29c. LICENSE NU O.C.M | · E . | and place, an | ≥ AUG | GNED (Month, Day, Year) 29,1995 |
| TO BE COMPLETED | 4 Homicide datarmined 29a. CERTIFIER Check only one) 2 MEDICAL EXAMIN 29d. SIGNATURE AND TITLE OF CERTIFIER | ER: On the basis of a ER HO COMPLETED CAU | xamination and/or | r investigation, | In my opinion, | 29c. LICENSE NU O.C.M | · E . | and place, an | ≥ AUG | GNED (Month, Day, Year) |



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| The law requires that the death certificate be executed writhin 24 hours after death. Page 6 may be retained by the hospital or attending physician. | od by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | h and Mental Hygiene prior to burial: cremation, or removal. | item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writhin 24 hours after death | een signed by the attending physician ar | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exar |

| 1 - STATE REGISTRAR | TATE OF MARYLANI | D / DEPARTM | | | MENTAL | HYGIEN REG. NO. | E | | |
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| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE (| OF DEATH | | 3. | TIME OF DEATN |
| Donuthy Anne | 2 Landsn | 200 | | | | um B | 8 192. | | 2:2000 |
| | | (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS | | | 7. DATE OF BIRTH 8 | | | BIRTHPL A | CE (State or Foreign |
| 212-)4-0934 1 | M 2 PF 80 | YRS. | CITY, TOWN OR L | | JU17 | | 9c. COUNTY | alt. | Maryland |
| 325 Stonewall Road | | | | | | | Back | | |
| 10e. STATE 10b. COUNTY | | | | | | | | 104 | d. INSIDE CITY |
| 11017 2 1101 | timore | Cato | nsville | | | | | | LIMITS? |
| 100. STREET AND NUMBER 325 Stonewall Road | | 10f. ZII | 21 | 228 | | | ed States | | |
| | 1 Never Married 2 Merried FORCES? 1 YES 2 | | | | can, Puerto Ricari, atc.) | | | RACE — American Indian, Black, White, etc. Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade com | DECEDENT'S USUA (Give kind of work of | | f working | 16b. | KIND OF BUS | SINESS/INDUS | TRY | White | |
| | ollege (1-4 or 5+) | e (1-4 or 5 +) Housev | | | | own home | | | |
| 17. FATNER'S NAME (First, Middle, Lest) | <u></u> | | | . MOTHER'S NA | ME (First. N | ficiclin. Maiclen | Surnamel | | |
| Charles Paff | | | | | Meti | | | | |
| 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRES: | | | RESS (Street and | Number or Rural | Route Numb | er, City or Tow | n, State, Zip Co | de) | |
| Mrs. Janice Huff | | | | | | sville | | 2122 | .8 |
| 20e. METHOD OF DISPOSITION 1 Donalton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION/Name of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of Commence of C | | | | | | | | | |
| 21. SIGNATURE OF THE ERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. | | | | | | | | | |
| Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 211 23. PART Aniel the diseases, or complications that coused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxima | | | | | | | | | |
| Interval Between Onset and Dash disease or condition resulting in death) Due to (or as a consequence or): Sequentially list conditions. | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other algorificent conditions of | | | | ause given in | given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| DID TOBACCO USE CONTRIB | | | | UNCERTAI | Ν□ | | | | |
| | OSPITAL: | PLACE OF DEATH (C | HER: | | | | | | |
| 1 TYES 2 NO 1 (| Inpatient 2 ER/Outpatie | 28b. TIME OF | Nursing Home 28c. INJUR | | | | | - | |
| 1 Netural 5 Pending | (Month, Day, Year) | INJURY | M 1 YES | ? | 280. DES | CHIBE HOW | NJURY OCCUP | IEU | |
| 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, atc. (Specify) | At home, ferm, street | t, factory, office | | 261, LOC. City | ATION (Street or Town, State) | and Number or | Rural Roul | e Number, |
| 29a. CERTIFIER 1 CERTIFYING PHYSICIAN One) 2 MEDICAL EXAMINER: 0 | I I: To the best of my knowledge In the basis of exemination en | | | | | | | euse(e) as | nd manner se stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 2 | 9c. LICENSE NU | MBER | | 29d. DATE S | IGNED (M | onth, Day, Year) |
| cen line | cus MD | | | 0290 | ,85 | | Sugar | -ma | 40 9 19 |
| 31. DATE FILED (MOQTIL 1995 | | 10 Caur | | 2 | 1113 | 3 | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

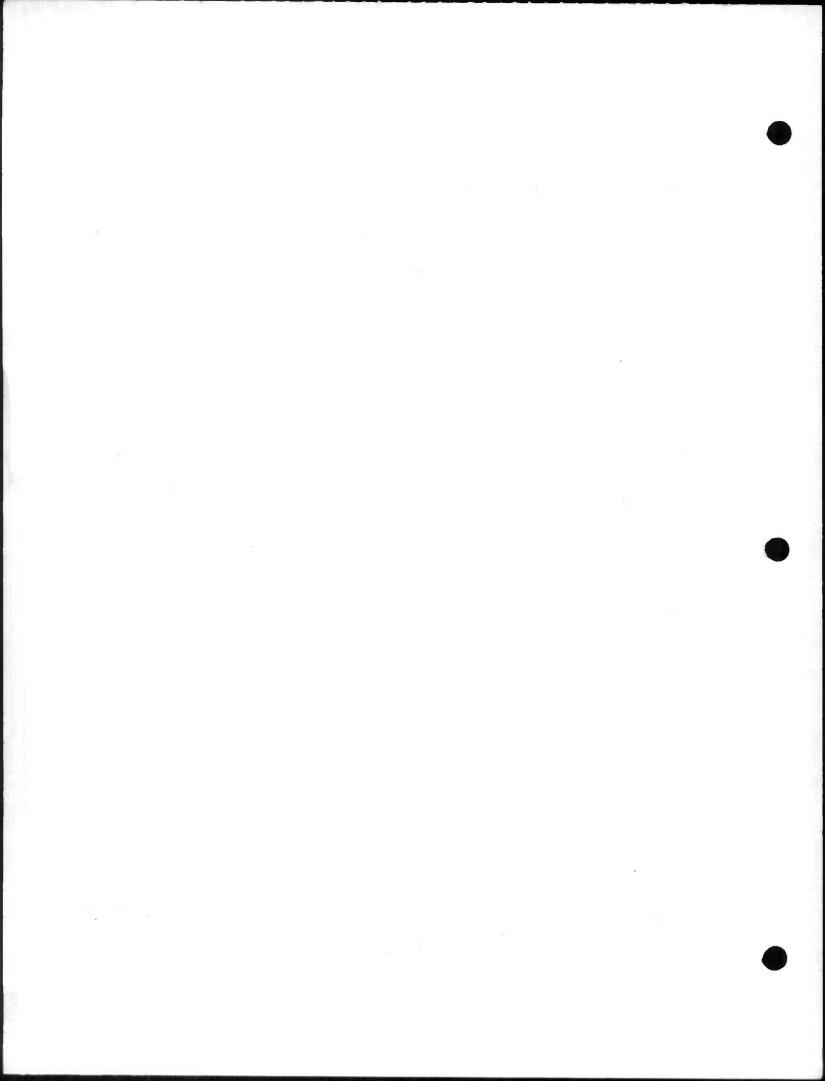
| | REGISTRAR | | | | ICALE | . Or | DEA | | | REG. NO. | | | |
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| | t. OECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. D/ | ATE OF DEATH | | | 3. TIME OF DEATH |
| | I and a Diament I | - 4- 4 | | | | | | | | ONTH DA | | YEAR | 0 004 |
| | Louis Edward I | | | | | | | | | <u>eptember</u> | 8, | 1995 | 8:00A M |
| | | | 8. AGE (In yrs. les | t birthday) | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 7. DA | NTE OF BIRTH lonth, Day, Year) | | 8. BIRTHI Country | LACE (State or Foreign |
| | 217-24-0994 | 1 X M 2 - F | 67 | YRS. | MORTHS | DAYE | HOURS | -MIN. | Jul | ly 5, 19 | 28 | | ryland |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | | 9h CITY | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | |
| œ | 9016 Carlisle Avenue | | | | | | | OH OF OE | LPSI FI | | | | |
| <u>ō</u> | | | | | Bal | ltim | ore | | | | Ba | 1timo | ore |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| # 1 | 10a. STATE 10b. COUNTY | | | 10c. CfT | Y, TOWN O | R LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| <u>a</u> [| MD Baltimore | | | | 1timc | ore | | | | | | ŀ | t TES 2 T NO |
| 4 | 10e. STREET AND NUMBER | | | | | 104 | ZIP COOL | | | | 10+ CIT | TEN OF W | HAT COUNTRY? |
| 2 | 9016 Carlisle Avenue | | | | | 101 | | | | | - | | |
| FUNERAL DIRECTOR | | | | | | | 212 | 36 | | | | U.S.A | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. AR | MED | 13. V | WAS DEC | ENDENT O | F HISPAN | IIC ORI | GIN? (Specify Yes | or No- | 14. RACE | - American Indian, White, atc. |
| | 1 Never Married 2 Merried | IF YES, GIVE W | YES 2 N | 10 | " | yes, spe | 2 A NO | n, Mexicar Specify | n, Puer | rto Rican, etc.) | | Black, | White, etc. |
| B | 3 Widowed 4 Divorced | Korean | | | 1 ' | | 22110 | ороспу | ,. | | | Specin | White |
| COMPLETED | 15. DECEDENT'S EDU | | 16a DE | CECENT'S | USUAL OC | CHRATIC | M | | | 16b. KIND OF BUS | 1000000 | | |
| Ë | (Specify only highest grade | completed) | (G) | | vork done di | | | g | | IND OF BUS | MESS/INI | DUSTRY | |
| ا ت | Elementary/Secondary (0-12) | College (1-4 or 5+) | _ | | | | | | | | | | 100 |
| 8 | 12 | 3 Yrs | Re | pair | man | | | | | Telep | none | | |
| 0 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | ER'S NA | ME (Firs | st, Middle, Malden : | (umame) | | |
| | John Grill | | | | | | M | ario | C+ | anton | | | |
| 띪 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | _ | | | | |
| 2 | | | | | | | | | | lumber, City or Town | | | |
| | Dolores Lottes | | 9 | 016 (| Carli | sle | Avei | nue l | Bal | timore, | MD : | 21236 | |
| | 20s. METHOD OF DISPOSITION | | 20b. PLACE | AND DATE | OF DISPOSI | | | | 0 | 11/95 LOC | ATION - | City or Toy | rn. State |
| | 1 XBurial 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | oval from State | cemetery, crea | | | | | | | 11/95 | 3-1+ | o. MD | |
| | 21. SIGNATURE OF FUNDALL SERVICE DO | ENSE | Saint | l ose j | ph's | Chu | rch (| eme | ter | y | Jart | O. IID | |
| ł | . (1) (7) 11 0/1 | | | | 44 | IAME AN | U ADDNES | S OF TAL | CHLITT | The Dia | nel | Fune | ral Home |
| | The Dippel Funeral Home 7110 Belair Road Baltimore, MD 21206 | | | | | | | 1206 | | | | | |
| | 23. PARD I. Enter the diseases or o | omotications hat | caused the de | eth Do n | ot enter t | 10 | do of dut | | oau | Darcino | , , | TID Z | |
| H | shock, or heart fallylre. | List only one caus | e on each line. | atii. Do ii | ot enter t | tira irror | de or dyr | ng, sucr | 1 84 6 | ardiac or reapii | atory an | reat, | Approximata interval Between |
| - 1 | IMMEDIATE CAUSE (Final | | | | . 1. | , | - 1 | . 4 1 | 1 | | | | |
| | disease or condition | . Proles | wire | Q | (ano | - | an | uch | ula | hmas | | | 15 mins. |
| - 1 | | DUE TO (| OR AS A CONSEC | CONSEQUENCE OF): | | | | | | . 9 | | | |
| 2 | | Profes | Dele | Cardial arrhythmias. | | | | | him | 10-15 min? | | | |
| ੁ∥ | Sequentielly list conditions, | D | OR AS A CONSEC | WENCE OF | D: | | | 100 | | | 1 | 0, 1011 | - |
| A | If any, leading to immediate cause. Enter UNDERLYING | | | V | | | | | | i l | | | |
| | CAUSE (Disease or Injury | CAUSE (Disease or Injury C. | | | | MOSOUS AD | | | | | | | |
| 67 H | that initiated events DUE TO (OR AS A CONSE | | | | NSEOUENCE OF): | | | | | | | | |
| | | DUE TO (| | | | | | | | | | | |
| ERTIFI | that initiated events resulting in death) LAST | DUE TO (| | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | | |
| | PART ii. Other significant condition | e contributing to | leeth but not re | esulting i | n the und | deriying | ceuse g | iven in i | Part I. | 24a, WAS AN | | | WERE AUTOPSY FINDINGS |
| | PART II. Other algnificant condition | e contributing to | deeth but not re | exulting i | n the und | derlying | ceuse g | lven in i | Part I. | PERFOR | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDICAL | PART II. Other algnificant condition | e contributing to | leeth but not ro | exulting i | in the und | derlying | ceuse g | lven in i | Part I. | 24a, WAS AN / PERFORI | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| EDICAL | PART II. Other aignificant condition CO PD 9 | d. e contributing to, d | in Ti | le Mon | ns · | 3 | | | _ | PERFOR | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDICAL | PART II. Other aignificant condition OPD Diales DID TOBACCO USE CONTE | d. e contributing to, d | JSE OF DEA | KOMO1 | s □ N |) O | | ERTAIN | _ | PERFOR | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| EDICAL | PART II. Other aignificant condition CO PD 9 | e contributing to, de la la la la la la la la la la la la la | JSE OF DEA | KOMO1 | S N | IO 🔲 | | | _ | PERFOR | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| EDICAL | PART II. Other aignificant condition PART II. Other aignificant condition DID TOBACCO USE CONTI | d. e contributing to, d | JSE OF DEA | TH YE | S N | IO 🗆 | UNC | ERTAIN | - - - - | PERFOR | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| EDICAL | PART II. Other aignificant condition DID TOBACCO USE CONTI | RIBUTE TO CAU HOSPITAL: 1 Inpetient 2 280. OATE OF H | JSE OF DEA 26. PLAC ER/Outpatient 3 | TH YE OF DEAT DOA 26b. TIM | S N H (Check or OTHER: 4 Nursi | IO ing Home 28c. INJL | UNC 5 D Ra | ERTAIN | N 🗀 | PERFORI | NED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| PHYSICIAN: MEDICAL | PART II. Other aignificant condition PART III. Other aignificant condition PD 9 DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | RIBUTE TO CAU | JSE OF DEA 26. PLAC ER/Outpatient 3 | TH YE E OF DEAT | S N H (Check or OTHER: 4 Nursi | nly one) ing Home 28c. (NJL WO) | UNC | ERTAIN | N 🗀 | PERFORI | NED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| EDICAL | PART II. Other aignificant condition PART III. Other aignificant condition PD 9 DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | RIBUTE TO CAL HOSPITAL: 1 Inpetient 2 28a. OATE OF B (Month, Day) | JSE OF DEA 26. PLAC ER/Outpatient 3 NJURY (, 'Year') | TH YE E OF DEAT DOA 26b. TIMI | S N H (Check or OTHER: 4 Nursi | IO inly one) : ing Home 28c. (NJt WOI 1 Y | UNC 5 PRO | ERTAIN | 6 O O | PERFORI 1 YES 2 ther (Specify) DESCRIBE HOW IN | MED? | CURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | PART II. Other aignificant condition COPD DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be | RIBUTE TO CAL HOSPITAL: 1 Inpetient 2 28e. PLACE OF | JSE OF DEA 26. PLAC ER/Outpatient 3 | TH YE E OF DEAT DOA 26b. TIMI | S N H (Check or OTHER: 4 Nursi | IO inly one) : ing Home 28c. (NJt WOI 1 Y | UNC 5 PRO | ERTAIN | 6 O O 28d. C | PERFORI | MED? | CURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | PART II. Other algnificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 2 Accident Investigation | RIBUTE TO CAL HOSPITAL: 1 Inpetient 2 28e. PLACE OF | JSE OF DEA 26. PLAC ER/Outpatient 3 NJURY ('ber') | TH YE E OF DEAT DOA 26b. TIMI | S N H (Check or OTHER: 4 Nursi | IO inly one) : ing Home 28c. (NJt WOI 1 Y | UNC 5 PRO | ERTAIN | 6 O O 28d. C | PERFORI 1 YES 2 ther (Specify) DESCRIBE HOW IN | MED? | CURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | PART II. Other aignificant condition PART II. Other aignificant condition DID TOBACCO USE CONTI S. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | RIBUTE TO CAU HOSPITAL: 1 Inpetient 2 28e. PLACE OF Building, et | JSE OF DEA 26. PLAC ER/Outpatient 3 NJURY (, Year) INJURY — At hortc. (Specify) | TH YE E OF DEAT DOA 26b. TIMI | S N H (Check or OTHER: 4 N Nursil | nily one) : ing Home 28c. INJL WOO 1 Y | UNC 5 PRe JRY AT RK? ES 2 | ERTAIN aldence (| 6 O O 28d. E | PERFORI 1 YES 2 ther (Specify) DESCRIBE HOW IN OCATION (Street a) | JURY OC | CURED or Rural Ro | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memal Hypiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 | - | FOR STATE REGISTRAR |
|---|------|---------------------------|
| | 1. D | ECEDENT'S NA |

| | REGISTRAR | | CERTIFIC | AIEU | F DEATH | REG. NO. | | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) GENEVIEVE | F | • | LAI | 19 | 2. DATE OF DEATH DATE OF SEPT 09 | | 3. TIME OF DEATH | | |
| | 215-18-6286 | □ M 2 📈 F | | DNTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) MAY 18 / | 923 | BIRTHPLACE (State or Foreign COUNTY) | | |
| FOR | 98. FACILITY NAME (If not institution, give street GOOD SAMARITAN RESIDENCE OF DECEDENT | HOSPITAL | • | | TO OR LOCATION OF DI | 9c. COUNTY | OF DEATH | | | |
| DIRECTOR | 100. STATE 10b. COUNTY MARYLAND N/A | 1 | | TOWN OR LO | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 4900 WILLSHIRE | IMORE MD | | 10t. ZIP CODE 2/206 | | 10g. CITIZEN OF WHAT COUNTRY? U.A.O. | | | | |
| В | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | 2 10 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes of it yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | | or No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) | riON mpleted) College (1-4 or 5+) | life. Do NOT use i | k done during etired.) | most of working | 16b. KIND OF BUS | SINESS/INDUST | | | |
| OMPL | 87 h 17. FATHER'S NAME (First, Middle, Last) | N/A | HOME | MAKC | 18. MOTHER'S NA | AME (First, Middle, Meiden | Surneme) | | | |
| BEC | ROBERT BEDFORD 18a, INFORMANT'S NAME (Type/Print) | | 405 11411 1110 41 | DDDF00 (0) | | IELLA DA | | | | |
| ٩ | ROBERTA B. PATR | ICK | 4418 | SHAL | IROCK AV | E BALTIMO | PRE MI | 7. 21206 | | |
| | 20s. METHOD OF DISPOSITION 1 Suriel 2 Cremellon 3 Remove 4 Donation 8 Other (Specify) | ol from Stata C0 | b. PLACE AND DATE OF metery, cremetory of othe IMMANUEL | LUT t | M32 H2 I | 9/14 6 | | ORE MD. | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY #ARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MD.21234 | | | | | | | | | |
| | 23. PART i. Enter the diseases, or cor shock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death) | ACUTE | aach lina. | enter the | mode of dying, suc | | iratory arrest | Approximate Interval Between Onset and Death | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DIA RET | | モレ | Lirw | | | nort Tite | | |
| MEDICAL C | OSTEOMYELITIS PERFORMED? 1 VES 2 NO | | | | | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| | DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL | BUTE TO CAUSE (| OF DEATH YES | | | NX | | | | |
| PHYSICIAN | EXAMINER? | HOSPITAL: Inpatient 2 - ER/Ou | | OTHER: | Home 8 - Residence | 8 Other (Specify) | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | | RY | INJURY AT WORK? | 28d. DESCRIBE HOW | NJURY OCCUP | BED | | |
| 2 | 3 Suicide 8 Could not be 4 Homicide datermined | 28e. PLACE OF INJUR building, etc. (Sp | RY — At home, term, etn ec/fy) | eet, factory, | office | 281. LOCATION (Street City or Yown, State, | | Rural Route Number, | | |
| COMPLET | cont orny | AN: To the best of my kno | | | | | | ause(a) and manner ee stated, | | |
| BE | 29b. SIGMATURE AND TITLE DE CERTIFIER | | MD | | P-07 | -618 | 29d. DATE S ►SE | PT-11TH 1995 | | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | SW-BC | DAITE | rint) | GOOD | SAMAK | RITAN | Hosp. | | |
| | SEP1 1 1995 | Jalia Da | SWATURE CONSULTA | | | | | | | |

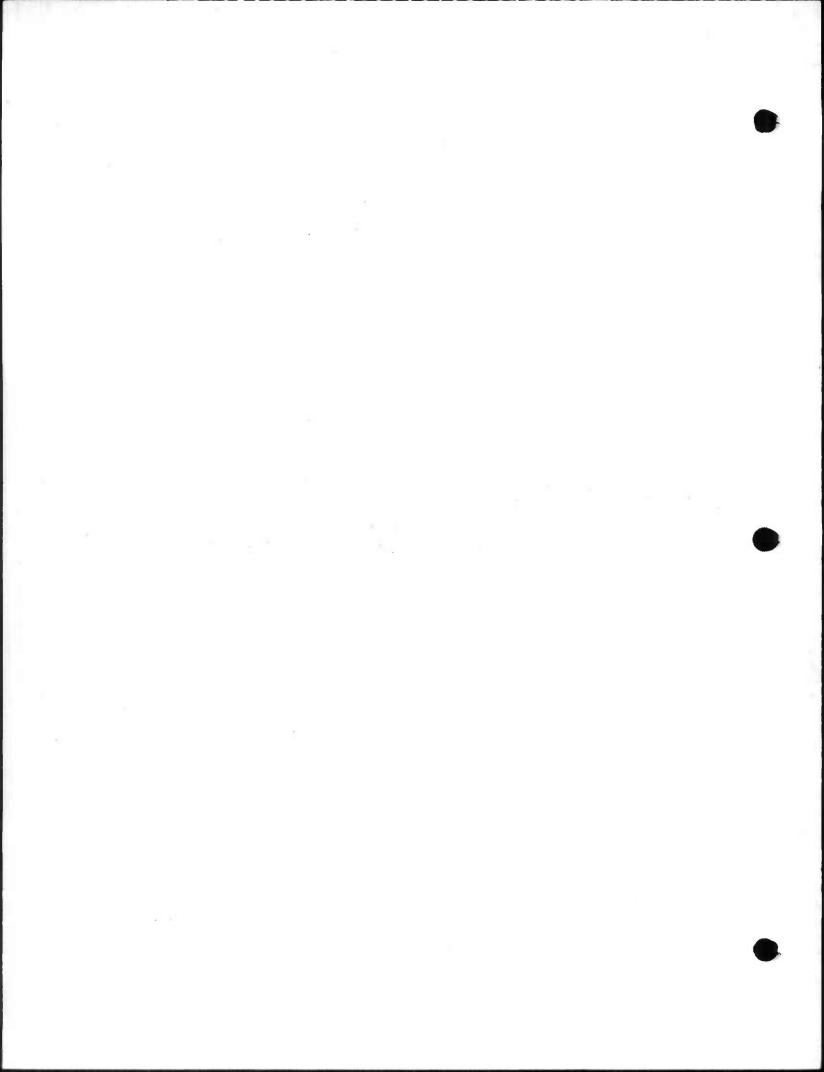




DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Fours after death. Page 6 may be retained by the hospital or attending physician. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1 2 should |
| be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | TATE OF MARYLAND / CE | DEPARTMENT ERTIFICATE | | MENTAL HYGIENE REG. NO. | | | |
|------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------|------------------|------------------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | <u> </u> | 2. DATE OF DEATH DAY | | 3. TIME OF DEATH | |
| | SAEMANN 4. SOCIAL SECURITY NUMBER 5. S. | LEO | | | 0 2 | 7 95 | 12:15 " | |
| | | M 2 □ E | | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | ITHPLACE (State or Foreign intry) | |
| | 9a. FACILITY NAME (If not institution, give street ar | nd number) | 9b. CITY, 1 | OWH DR LOCATION OF DE | 04/16/11 EATH | 9c. COUNTY OF | GERMANY DEATH | |
| OR | VANTAGE HOUSE | | CO | LUMBIA | | HOW | ARD | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN OR | LOCATION | | | 10d. INSIDE CITY | |
| | MARYLAND HOW | <i>I</i> ARD | COL | UMBIA | | | t YES 2 ND | |
| 3AL | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | 10g. CITIZEN DI | F WHAT COUNTRY? | |
| FUNERAL | 5400 VANTAGE POIN | IT ROAD WAS DECEDENT EVER IN U.S. ARI | aten. I to tu | 21044 | | | USA | |
| ВУ | 1 Never Merried 2 X Merried F | F YES, GIVE WAR DR DATES | II II | AS DECENDENT OF HISPAN res, specify Cuben, Maxical YES 2 [X] NO Specify | n, Puerto Rican, atc.) | Bi | NCE — American Indian, ack, White, atc. acity: White | |
| TEC | ts. DECEDENT'S EDUCATION (Specify only highest grade complete) | leted) (G/ | CEDENT'S USUAL OCC | UPATION ring most of working | 16b, KIND OF BUS | INESS/INDUSTRY | | |
| PLE | Elementary/Secondary (0-12) Coll | lege (1-4 or 5+) Bak | Do NDT use retired.) | | Food | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 18, MOTHER'S NA | ME (First, Middle, Meiden S | Surname) | | |
| BE C | ADAM JOSEPH SAEMANN | | | ANNA MAR | IA BECKER | _ | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) (WifElizabeth M. Saeman) | (e) 19h | MAILING ADDRESS | Street and Number or Rural F | Number, City or Town | State, Zip Code) | Apt. 416 | |
| | 20a. METHOD OF DISPOSITION | 20h PLACEA | AND DATE OF DISPOSIT | use-5400 Va | | ATION — City or | 7.1.1.4.4 | |
| | 1 Donation 5 Other (Specify) | rom State cemetary, crei | matory or other place) | | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENSES | ERgnald Wade, | Dir. Sta | me and address of factory | Board-655 | W. Balt | imore Street | |
| | mum/// | The same | Rm. | B026-Baltin | nore. Maryl | and 21 | | |
| | 21 PART L Enter the diseases, or compl shock, or heart fallure. List of IMMEDIATE CAUSE (Final disease or condition | only Dne cause on each line. | | ne mode of dying, suct | n ss cerdiec or reepir | atory arrest, | Approximate interval Between Onset and Death | |
| | reculting in desth) | DUE TO (DR AS A CONSEC | OLIENCE OFF | | | | 1 week | |
| z | | PARKINS | ons R | 158456 | | 5 YEAR | | |
| OT I | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSED | DUENCE OF): | 1 | | | | |
| CERTIFICATION | CAUSE (Disesse or injury that initiated events | DUE TO (OR AS A CONSEC | DUENCE DF): | | | | | |
| E | resulting in daeth) LAST | | | | | | | |
| AL CI | PART II. Other eignificant conditions con | itributing to death but not re | acuiting in the unde | erlying cause given in | Part i. 24s. WAS AN A | WTOPSY 2 | 4b. WERE AUTOPSY FINDINGS | |
| S | | 0. | | | PERFORM | SN-1 | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | ~ | 1 YES 2 NO | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBU | | TH YES NO | | 10 | | | |
| SICI | EXAMINER? HOS | SPITAL: Inpatient 2 ER/Outpatient 3 | OTHER: | g Home 5 🗆 Residence | 6 ☐ Other (Specify) | | | |
| PHY | | 28a. DATE DF INJURY (Month, Day, Yber) | | Bc. INJURY AT WORK? | 28d. DESCRIBE HOW IN | JURY OCCURED | | |
| B≺ | 1 Natural 5 Pending 2 Accident Investigation | ACC DE MANERO | М | 1 YES 2 ND | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY — At hor building, etc. (Specify) | me, term, atreet, tactor | y, office | 28f. LOCATION (Street ar City or Town, State) | d Number or Rura | Il Route Number, | |
| Ë | 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: | To the best of my knowledge, das | ath occurred at the time | , date and place, and due | to the cause(s) and mone | ner se stated | | |
| COMPLETED | | the basis of examination and/or in | | nion, death occured at the | time, data and place, and | due to the cause | | |
| TO BE | WILLIAM FLA WAS | EX MD | 4.27 (Supp. Defect) | 29c. LICENSE NUM | 08 | DATE SIGNI | ED (Month, Day, Year) UST 29, 1895 | |
| | William Flo | WERJ M 32. REGISTRAR'S SIGNATURE |) 10. | 55 ZIH | He Putux. | nt E | Slumbia | |
| | OFD4 1 400F | Chi Davilson | Ordall. | | | | | |
| | SLI'11 1995 | J | A A S A S A S A S A S A S A S A S A S A | | | - | DHMH-16 Rev 1/89 | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

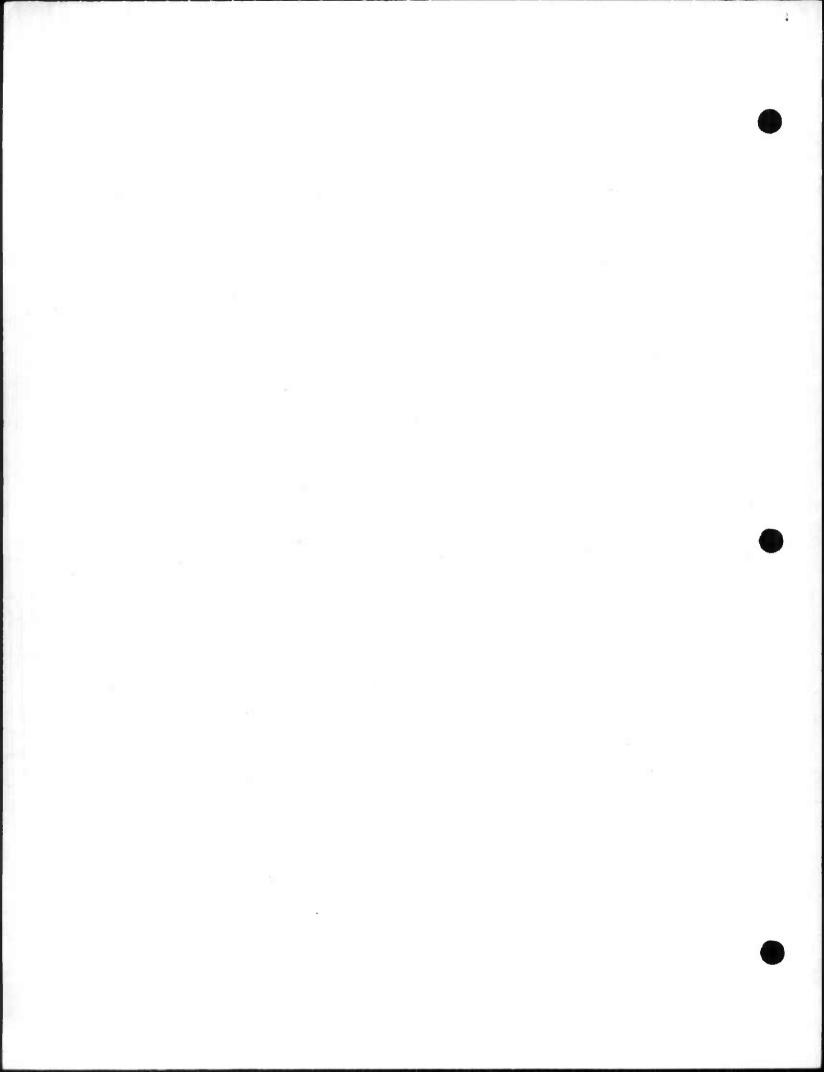
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| E | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|-------|-----------------------------------------------------|----------|
| STRAR | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE OF REGISTRAR | | RTMENT OF HEALTH AND | MENTAL HYGIENE | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | 3, TIME OF DEATH |
| | AZALEE MCB | CIDE. | | SEPTEMBELL 9 | 1995 9:30 AM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. lest birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS | 7. DATE OF BIRTH | BIRTHPLACE (State or Foreign |
| | 239-34-5269 1□ ₩2 🗹 € | 73 YRS. | MONTHS DAYS HOURS MIN. | (Month, Day, Year) Aug 4, 1922 | South Carolina |
| | 9e. FACILITY NAME (If not institution, give street end number) | | 9b. CITY, TOWN OR LOCATION OF | | COUNTY OF DEATH |
| DIRECTOR | Harbor Hospital | | Baltimore | | n/a |
| 2 | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | 10c. CIT | Y. TOWN OR LOCATION | | 10d. INSIDE CITY |
| 8 | Maryland n/a | | | | LIMITS? |
| | 100. STREET AND NUMBER | | Baltimore 10f, ZIP CODE | 100 | 1 TYES 2 NO |
| FUNERAL | 2212 Annapolis Road | | 21230 | | |
| 3 | 11. MARITAL STATUS 12. WAS DECEDE | NT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISE | ANIC ORIGIN? (Specify Yes or N | USA - 14, RACE — American Indian. |
| BY F | | 1 YES 2 NO | If yes, specify Cuben, Mexi 1 YES 2 X NO Spe | | Black, White, etc. Specify: |
| | | | | | Black |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give kind of | USUAL OCCUPATION work done during most of working | 16b. KIND OF BUSINES | S/INDUSTRY |
| 7 | Elementary/Secondary (0-12) College (1-4 or 5 5th Grade | +) | | | |
| M | 17. FATHER'S NAME (First, Middle, Lust) | HO | usekeeping | Privat. | |
| | Henry McCucheon | | | | (me) |
| BE | 19s. INFORMANT'S NAME (Type/Print) | 19b. MAILING | ADDRESS (Street and Number or Run | tha Green | te 7/o Codel |
| 5 | Patricia Ross | | Annapolis Road | | |
| | 20e. METHOD OF DISPOSITION | 20b. PLACE AND DATE | OF DISPOSITION (Name of | | Maryland 21230 |
| | 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | King Memor | ther place) | Seint | more County, MD |
| | 21, SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF | Mutter Fu | neral Homes Inc |
| - 6 | - sevin Parke | ~ | 2501 Gwynns | Falls Parkway aryland 2121 | neral nones, me. |
| | 23. PART I. Enter the diseases, or complications th | et ceused the death. Do | I Baltimore, M | aryland 2121 | y arrest, Approximate |
| 1 | shock, or heert fallure. Liet only one ce | use on each line. | Interval Between Onset and Death | | |
| | diagon or condition | COMPRIA MES | LAR ACCIDENT | | MINUTES |
| | DUE TO | OR AS A CONSEQUENCE O | F): | | 141100127 |
| z | C b C | ARUTO ARTER | V DISEASE | | MONTHS |
| 일 | in any, leading to ininiediate | | | | |
| 2 | CAUSE (Disease or Injury | HIGH BLOOD | | | years |
| E | that initieted events resulting in death) LAST | (OR AS A CONSEQUENCE O | F): | | |
| CERTIFICATION | d | | | | |
| A P | PART II. Other significant conditions contributing to | | , | n Part I. 24a. WAS AN AUTO PERFORMED? | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s |
| MEDIC | CHLON | IC NEWAL FAIL | URE (DIALYSIS) | 1 NES 2 W | COMPLETION OF CAUSE |
| ME | 1440 | OTHY ROLDISM | | | 1 VES 2 NO |
| | DID TOBACCO USE CONTRIBUTE TO CA | USE OF DEATH YE | S NO UNCERTA | IN 🗹 | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF OEA | TH (Check only one) OTHER; | | |
| YS | 1 YES 2 NO 1 Inpetient 2 | ER/Outpatient 3 DOA | 4 Nursing Home 5 Residence | 6 Other (Specify) | |
| H | 27. MANNER OF OEATH 1 Natural 5 Pending 28e. DATE Of (Month, in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of | Pay, Year) 26b. TIM | URY WORK? | 28d. OESCRIBE HOW INJURY | Y OCCUREO |
| B | 2 Accident Investigation | DF INJURY — Al home, ferm, | M 1 YES 2 NO | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | etc. (Specify) | кгеет, тастогу, отное | 261. LOCATION (Street end Nu City or Town, State) | imber or Rural Route Number, |
| 9 | 290. CERTIFIER | | | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINER: On the best of the control of the best of the control one) | | | | |
| 8 | 29b. SIGNATURE AND TITLE OF CERTURER | Administrati endror investigatio | | | to the cause(e) end manner ee stated. |
| BE | 1 ha / 1 | | 29c. LICENSE N | | DATE SIGNED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU | SE OF DEATH ATEM 27 (3- | D292 | .70 | DEVT. 9, 1995 |
| | GERALD M COWDER, 1 | | E. FORT AVE | BALT. MD. 71 | 730 |
| | | ARIS SIGNATURE | | 01 | |
| | SELT 1939 Amy and | and the same | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | REGISTRAR | | ERTIFICA | E OF DEATH | | REG. NO. | | |
|---------------|------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------|-----------------|----------------------------------|------------|------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 4 | W. 27 | 2. DATE O | | YEAR 3 | . TIME OF DEATH |
| | 14011 | DOMINIC | Mu | Llins | Sen | + 8 9 | 5 | 12:45 AM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. II | MONTH | DER 1 YEAR | 7. DATE OF | Day, Year) | Country) | ACE (State or Foreign |
| | 9a. FACILITY NAME (If pot institution, give : | | YRS. | | AUG. | | | MD |
| Œ | 12100 | 0 0 | 1 % | TY, TOWN OR LOCATION OF I | | 9c. COUNT | | тн |
| CTOR | RESIDENCE OF DECEDENT | Day Koad | | altimol | ੲ | | A | |
| DIREC | 10e. STATE 10b. COUNT | | 10c. CITY, TOW | OR LOCATION | | | Æ | M. INSIDE CITY |
| 5 | WO | A | Da | ltimore | | | 1 | YES 2 NO |
| MAL | 10e. STREET AND NUMBER | 0 0 | | 10f. ZIP CODE | - 2 | 10g. CITIZE | N OF WH | AT COUNTRY? |
| FUNERAL | 1110 | way hoad | | 2120 | 8 | U | SA | • |
| FU | 1. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 | RMED 1 | 3. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic | | | Black, V | American Indian, Vhite, atc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TYES 2 NO Spec | | | Specify: | Riack |
| ED | 15. DECEDENT'S EDU | | ECEDENT'S USUAL | OCCUPATION | 16h K | IND OF BUSINESS/INDU | RTEV | DIGCK |
| E | (Specify only highest grade Elementary/Secondary (0-12) | completed) / | Give kind of work dor le. Do NOT use retired | ne during most of working | | | . 1 | |
| COMPLET | 12th | | EAT | UTTER | | YTANC | MA | RKET |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | 11 11 | | 18. MOTHER'S N | AME (First, Mic | (dle, Maiden Surname) | | |
| BE | ROBERT LEI | DIS Mullin | 25 | CALL | -LE | GOLDEN |) | |
| 2 | 199. INFORMANT'S NAME (Type/Print) | 11. | b. MAILING ADDRE | SS (Street and Number or Rura | Boute Number | City or Jown, State, Zip C | ode) | 1 0 |
| | KOBERT L. M | ullins 1 | 1405 | Kicksway | Koac | & Dalto | . M | d 21208 |
| | 20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Reg | oval from State cemetery, ci | AND DATE OF DISP | 0) 1 | DATE | 20c. LOCATION — CH | y or Town | , State |
| | 4 Donation 5 A Other (Specify) | The Date | ia Kido | S NAME AND ADDRESS OF A | 4154 | Da 10 | ĹΜ, | ,OL |
| | ► VXI., | 51 + | 4 4 | PARCH FUN | 2566 | . Homes | Nes | T, 21215 |
| _ | - Buyus | D. DOM | (' | 4300 W | aboqs | h Aug. D | al-k | » Mcl |
| | 23. PART & Enter the diseases, or shock, or heat failure. | complications that caused the d List only one cause on each lin | eath. Do not ent e. | er the mode of dying, su | ch as cardia | c or respiratory arres | f, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | | A | | | | | Onset and Deeth |
| | disease or condition resulting in death) | 0 | ANONA | | | | | minutes |
| | | M + + T | QUENCE OF): | 0 500 | | | | 2 |
| 0 | Sequentially list conditions, | DUE TO JOR AS A CONSE | IC DIV | novial San | coma | - | | 2905 |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING | 5,100 | wind So | EN COMA | | | | 4/271 |
| Ĭ | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CONSE | QUENCE OF): | 01-0 | | | | 1-12 |
| CERTIFICATION | resulting in death) LAST | d. | | | | | | |
| 15000 | PART II. Other significant condition | as contribution to death but not | resulting in the | | na. L | | I was we | |
| EDICAL | The second segment contact | s continuing to beaut but not | resulting in the | underlying cause given in | Purt L. 2 | 4a. WAS AN AUTOPSY PERFORMED? | AV | ERE AUTOPSY FINDINGS AILABLE PRIOR TO |
| | - | | | | | ☐ YES 2 XHO | | OMPLETION OF CAUSE DEATH? |
| ≥ | DID TORACCO LISE CONT | DIBLITE TO CALLER OF DE | WE D | NO EVINICEOUS | | | 1 | YES 2 NO |
| A N | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | | CE OF DEATH (Che | | иП | | _ | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | OTH | IR: | | co.iii | | |
| £ | 27. MANNER OF DEATH | 28s. DATE OF INJUNY | 266. TIME OF | 28c, INJURY AT | - | UBE HOW BUILDRY OCCUP | HED. | |
| | 1 Natural 5 Pending | (Month, Day, Year) | M | WORKY 1 ☐ YES 2 ☐ NO | 33750000 | | | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 26s. PLACE OF INJURY AI N | ome, ferm, street, to | ictory, uffice | 28f. LOCATI | ON (Street and Number or | Runki Rout | a Number |
| ETED | 4 Homicide determined | building, etc. (Specify) | | | City or | Rwn, State) | | |
| 4 | 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my knowledge, d | eath occurred at the | time, data and place, and du | a to the cause | (a) and manner so stated | | |
| COMPL | | R: Dn the basis of examination and/or | | | | | | nd manner as stated. |
| 5 | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | 29c. LICENSE NU | | | 1 | orith, Day, Year) |
| ן מ | (francost | . Deglens | 11 | | 157 | ▶ 9 | 89 | 5 |
| 2 | 30. NAME AND ADD ESS OF PERSON WH | D COMPLETED CAUSE OF DEATH (ITE | M 27) (Type, Print) | | | | | |
| | JOSEPH H. | STEPHENS M.D. | 166 BOLT | ON ST. B | HIM | RE MID | 21. | 217 |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIGNATURE | | | | | | |
| - 11 | SEP 1 1 1995 | Jelia d'Audisor de | Wall | | | | | |
| | 01-1 1 1000 | | | | | | | |

95-5437-005

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

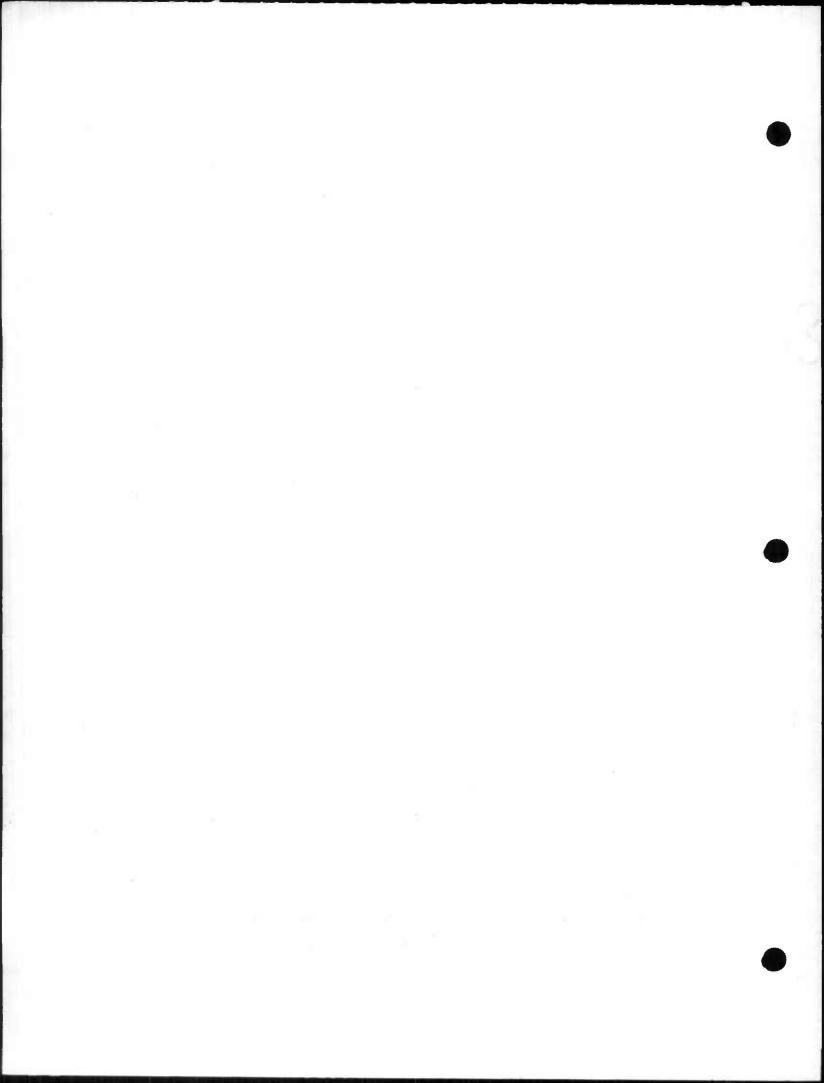
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| | FOR STATE REGISTRAR | STATE OF MARYL | | RTMENT OF I | | MENTAL HYGIEN REG. NO. | E | | | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------|------------------------------------------------|------------------------------------------------------------|----------|--------------|--------------------------------------------------------------------------|------|
| | 1, DECEDENT'S NAME (First, Middle, Lest) BENJAMIN | JOSEPH | <u></u> | MACKAL | JR. | 2. DATE OF DEATH MONTH SEPTEMBER | 8, | 55 | 3. TIME OF DEATH 9:47 | Αu |
| | 4. SOCIAL SECURITY NUMBER 215-74-4531 | 1 M 2 D F | (In yrs. last birthday) 34 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) NOV 01 19 | 60 | Mary | vland | n |
| TOR | 99. FACILITY NAME (If not institution, give st 113 CARAWAY ROA RESIDENCE OF DECEDENT | | | | ERSTOWN | PALTIMO | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | imore | 10c. CITY, TOWN OR LOCATION Reister | | | rstown | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |) |
| FUNERAL | | d, Apt. 1B | | | of. ZIP CODE 2113 | - | | USA | VHAT COUNTRY? | |
| BY FUI | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D | | If yes, a | | NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.) fy: | or No- 1 | 9 Speci | - American Indian, k, White, etc. | |
| COMPLETED | 16. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16e. DECEDENT' (Give kind of iffe. Do NOT | | ON ost of working | Portogo | | | | |
| BE | 12 17. FATHER'S NAME (First, Middle, Last) Benjamin Jo | | river | 18. MOTHER'S NA | Beverag ME (First, Middle, Maiden Rose A. Pa | Sumeme) | pan | у | | |
| TO BE | 199. INFORMANT'S NAME (Type/Print) Rose A. Mackall | | | | | Abute Number, City or Yow | | Code) | | |
| | 20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetton 3 Remove from State 4 Donation 5 Other (Specify) Date 20b. PLACE AND DATE OF DISPOSITION (Name of Methods of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Cont | | | | | | | | | |
| | 21. SIGNATURE OF SUMERAL SERVICE HOENSEE Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | | | nc. 21228 | | |
| | 23. PART I. Enter the diseases, or ahock, or heart failura. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Centre! | | shoth | | the acardiac or reap | 1/5 | | Approximate Interval Batw Onset and D | reen |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | с | A CONSEQUENCE | | | | | | | |
| MEDICAL CE | PART II. Other significant condition | a contributing to deeth i | but not resulting | g in the underlyi | ng ceuse given in | PERFO | | 24b | WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION DF CAU OF DEATH? | |
| | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | | YES NO [| | N D less | larly | - | 1 YES 2 NO | |
| YSICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Out | tpettent 3 🗆 DOA | OTHER: 4 Nursing Ho | me 5 [XResidence | 8 Other (Specify) | | | | |
| ED BY PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined | 28e. DATE OF INJURY (Month, Day, Year) Face of INJURY 28e. PLACE OF INJUR building, atc. (Spe | 95 Of | NJURY W | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW SULL STORY CON OF TOWN, State | sha ; | 4 , | Route Number, | |
| COMPLET | one | ICIAN: To the best of my know | wiedge, death occu | irred at the time, da | | of this Education only mis | | d. couse(| y (and | ed. |
| BE CO | 296. SIGNATURE AND TITLE OF CERTIFIE | 1, 1 | | | 29c. LICENSE NU | | | | (Month, Day, Year) | 19 |

111 Penn Street, Baltimore, Maryland 21201

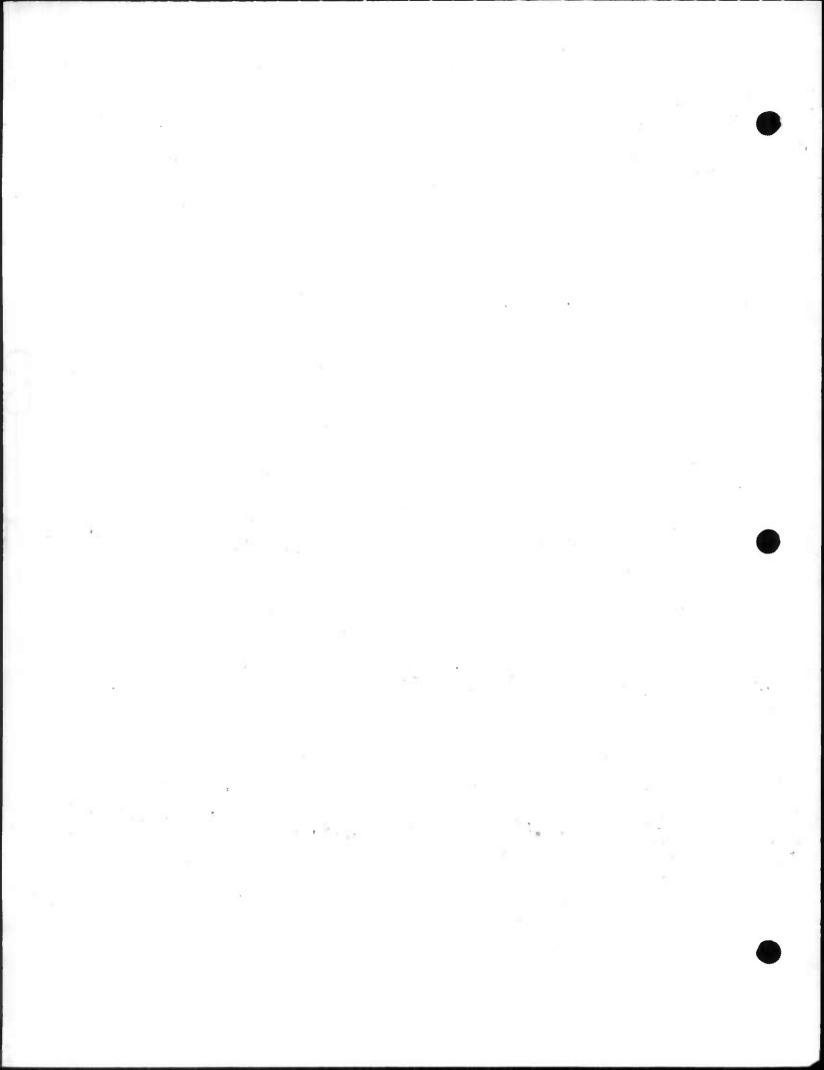
DHMH-16 Rev 1/89



| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Memal Hygiene prior to burlal, cremation, or removal. |

1 - STATE

| | | HEGISTHAR | | | CERTIF | ICALE | OF | DEATH | RI | EG. NO. | | |
|---------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------|------------------------------------|------------------------------|--------------------|-----------------------------------------|------------------------------|--------------------------|-------------------|-------------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF D | | | 3. TIME OF DEATH |
| | | Leo Jerome Mar | rtin | | | | | | 07 | O. | | 11:25 p. M |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In y | rs. lest birthday) | IF UNDER 1 | YEAR | IF UNDER 24 HRS. | 7. DATE OF B | IRTH | 8. BIR | THPLACE (State or Foreign |
| | | 214-76-5776 | 1 X M 2 F | 36 | YRS. | MONTHS | DAYS | HOURS MIN. | (Month, Day | | Cou | intry) |
| | | 214-76-5776 Se. FACILITY NAME (If not institution, give a | treet and number) | | | 9b, CITY, 1 | OWN O | R LOCATION OF DE | 03-19 | -195 | 9c. COUNTY OF | ryland |
| | Œ | 921 Wilmot Court | | | | Balt | | | | | DC. 000HTT OF | DEATH |
| | DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | |
| | ĕ | 10a. STATE 10b. COUNTY | 1 | | | Y, TOWN OR | | | | | | 10d. INSIDE CITY |
| | ā | Maryland | | | B | altim | ore | | | | - 143 | LIMITS? |
| | 4 | 10e. STREET AND NUMBER | | | | | 101. | ZIP CODE | | | 10a. CITIZEN OF | WHAT COUNTRY? |
| | FUNERAL | 921 Wilmot Court | | | | | - | 21202 | | | | S.A. |
| | Z | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U. | S. ARMED | 13 W | S DECE | ENDENT OF HISPAN | HC OBIGINS (C. | anifu Van a | | |
| | | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE V | YES 2 | 2 X NO | 1 11 | res, spe | cify Cuban, Maxica | n, Puerto Rican, | etc.) | 816 | CE — American Indian, ick, White, etc. |
| | ВУ | 3 Widowed 4 Divorced | IF TES, GIVE Y | INH OH DATE | 3 | 1 1 | | 2 □ NO specii, nknown | <i>/</i> : | | Sp | Black |
| | ED | 15, DECEDENT'S EDUC | | 16 | a. DECEDENT'S | USUAL OCC | UPATIO | N | 16h. KINI | OF BUSI | NESS/INDUSTRY | black |
| | | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | | (Give kind of a life. Do NOT us | vork done du le retired.) | ring mos | t of working | | | | |
| | 7 | 10th | 0011090 (1-0 0) | | Handymo | ın | | | 1 11 | nkno | w | 2.0 |
| nce | COMP | 17. FATHER'S NAME (First, Middle, Last) | | | riotrictoj irio | .,, | | 16. MOTHER'S NA | | | | |
| at | ЕС | unknown | | | | | | Sadie | | , walter of | orriente) | - 100 |
| Pell | 100 | | (cousin) | | 19b. MAIL ING | ADDRESS (| Street or | od Number or Rural F | | h. a. Tour | Onete The Octable | |
| not | 5 | Anita M. Baker | (Coustn) | | | | | urt-Bal | | | | 21202 |
| 9 | | 20a. METHOD OF DISPOSITION | | 20h DI | | | | | - | | | |
| examiner must be notified at once. | | 1 Burial 2 Cremation 3 Remo | oval from State | cemeter | ACE AND DATE (| ther place) | ON(Nan | ne or | OATE | 20c. LOCA | ATION — City or | Town, Stata |
| 10 | 11/4 | | ENSERO 0/ | 7 () (| 0'. | | | D ADDRESS OF FAC | | | | |
| 를 | | H. SIGNADINE OF FINERAL SERVICE LIC | Konalg | i wade | , ver. | Sta | ite. | Anatomu | Board- | 655 | W. Balt | imore Street |
| exa | | mala) | 1/1/1/1/1/ | yll | an . | | | 26-Balt | | | | 1201-1559 |
| lica | | 23. PART I. Enter the diseases, or o | complications the | t caused th | e death. Do r | ot enter th | ne mod | le of dying, suci | h aa cardiac o | or reapire | tory arrest | Approximate |
| E E | | anock, or neart railure. | List only one ceu | ee on each | line. | | | | | | | Interval Between |
| the | | iMMEDIATE CAUSE (Final disease or condition | rED | FRO | 11 11 | 2000 | / A | 0 100 | 1- h | _ | | Onset and Death |
| E, | | resulting in death) | . CER | OB AS A CO | MSEQUENCE OF | 1300 | LH | K MC | IUEN. | | | sudden |
| or other traumatic event, the medical | _ | | DRA | STHE | | MIT | 21. | 1 1/41 | VE | | | 20 |
| ten. | CERTIFICATION | Sequentially flat conditions, our TO (OR AS A CONSCOUENCE OF): NOTE TO (OR AS A CONSCOUENCE OF): OUR TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | |
| ET. | ξl | If any, leading to immediate oue to (or as a consequence of): | | | | | | | | j | | |
| ě | 프 | CAUSE (Disease or injury that initiated events | DUE TO | (OR AS A CO | NSEQUENCE OF | 7: | - | | | | | |
| 0 10 | E | resulting in death) LAST | | | | | | | | | | |
| | | | | | | | | | | | | - |
| any injury, | EDICAL | PART II. Other significant condition | | | | | | | | WAS AN AL | | b. WERE AUTOPSY FINDINGS |
| amy | 8 | Previous eprebral vascular accident. Rhamatic Performed? MAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | |
| \$ A | | | | | | | | | | | | |
| sho | Σ. | DID TOBACCO USE CONTE | RIBUTE TO CA | USE OF I | DEATH YE | S N |) M | UNCERTAIN | <u></u> | | | 1 YES 2 NO |
| n 23 | IAN: | 25. WAS CASE REFERRED TO MEDICAL | | | PLACE OF DEAT | | | OTTCERIAI | , 0 | | | |
| Hem | SICI, | EXAMINER? 1 YES 2 NO | HOSPITAL: | | | OTHER: | | | | | | |
| 6 | РНҮ | 27. MANNER OF DEATH | 25a. OATE OF | | 28b. TIM | | g Home Ic. INJU | 5 Residence | | | | |
| marked, | | 1 Natural 5 Pending | (Month, D | | INJ | URY | WOR | K? | 28d, DESCRIB | E HOW INJ | URY OCCURED | |
| | BY | 2 Accident Investigation | 38- BI 405 0 | P. Int. II IPAY | *** | | | ES 2 NO | | | | |
| 28 ls | | 3 Suicide e Could not be | building, | atc. (Specify) | At home, farm, s | treet, factory | , office | | 261. LOCATION City or Tow | (Street and m, State) | d Number or Rure | l Route Number, |
| ш 2 | | | | | | | | | | | | |
| f item | MPL | (Check only 1 CERTIFYING PHYSIC | | | | | | | | | | |
| Ë | CO | one) 2 MEOICAL EXAMINE | R: On the beels of a | amination an | d/or investigation | n, In my opie | nion, de | ath occured at the | time, date and p | place, and o | due to the cause | (a) and manner as stated. |
| RIA | Ш | 296. SIGNATURE AND TITLE OF PERTIFIER | | | | | | 29c. LICENSE NUM | BER | T | 29d. DATE SIGNE | D (Month, Day, Year) |
| IMPORTANT: IF | ω | Ausum 1/21 | mou | MI | 0 | | | 1979 | 92 | | > 8/2 | 1/95 |
| = | 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH | (ITEM 27) (Type. | Print) | | | - | | -/3 | 117 |
| | | SUSAN T. ZIE | | | | | 5 | HOSPITA | A) R | AIT | -1 MAD | E MO |
| | | 31. DATE FILED (Month, Day, Year) | 3.REGISTRA | R'S, SIGNATAT | RE # .A | | | , , , , , , , , , , , , , , , , , , , , | 12 0 | 1101 | -1 101 | ·E, F(U |
| | | SEP11 1995 | M. REGISTRA | who h | ardall | | | | | | | ĺ |
| L | | AND MAN VALUE | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be field within 72 hours after death with the State Dept. or health and Mental Hygher prior to burial, ceremation, or removal.

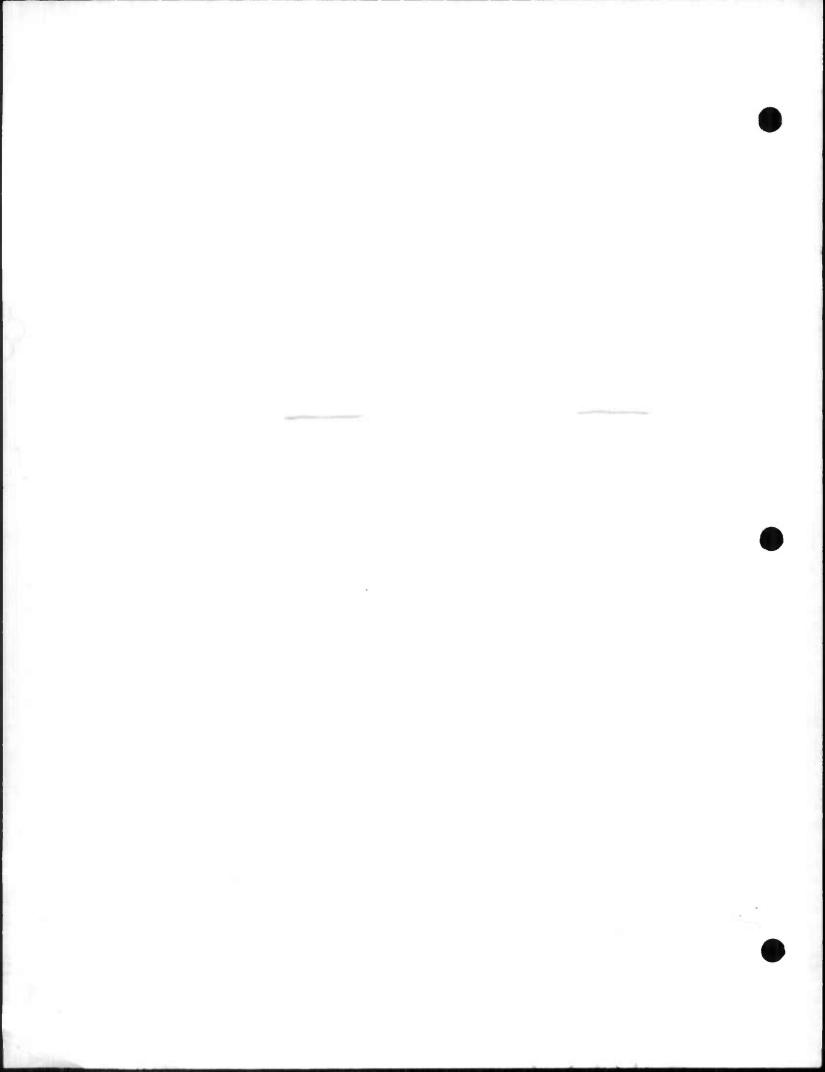
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event. the madical examinar must he manual at a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant and a constant a constant and a constant a constant a constant a constant and a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a constant a DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMENT OF ERTIFICATE OF | | MENTAL HYGIEN | |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------|
| | | A. M. 5. SEX 6. AGE (in yrs. Issue 43 | itche, | // IF UNDER 24 HRS. HOURS MIN. | 2. DATE OF DEATH | 3. TIME OF DEATH |
| 0 8 0 | 96. FACILITY NAME (If not institution, give stre BAYVIEW HOSP | | | ALTIMORE | | sc. COUNTY OF DEATH n/a |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYLAND | n/a | 10c. CITY, TOWN OR LOCA | ALTIMORE | CITY | 10d. INSIDE CITY LIMITS? 1 VES 2 \(\text{NO} \) NO |
| VERAL | 100. STREET AND NUMBER 1125 BRENT | WOOD STREET | 1 | 01. ZIP CODE 212 (| 02 | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES |
| BY FUN | 11. MARITAL STATUS VIA Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 ☐ YES 2 ☑ IF YES, GIVE WAR OR DATES | O If yes, s | CENDENT OF HISPAN specify Cuban, Mexical S NO Specify | | or No— 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| once. COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) 11 th | ompleted) (G College (1-4 or 5+) | CEDENT'S USUAL OCCUPAT the kind of work done during in Do NOT use retired.) | TON nost of working | Outside | SINESS/INDUSTRY |
| 75 | | ITCHELL | | IRE | | |
| be notified TO BE | - VIEGINIA R | EYNOLDS | | eland ST | REET, BALT | IMORE, MARYLAND #30 |
| must | 20s. METHOD OF DISPOSITION 1 A Burlal 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEY | | | | 9-13 LA | NSDOWNE, MARYLAND |
| a examiner | S. Valenci | a Hollan | WM. | C. MARCH | FH. <u>-</u> 1101 | E. NORTH AVENUE |
| event, the medical | IMMEDIATE CAUSE (Fine) | mplications that caused the dest only one cause on each line Chronic Re DUE TO (OR AS A CONSE | | | | ratory arrest, Approximate interval Batween Onset and Death |
| or other traumatic | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | Dement DUE TO (OR AS A CONSECUTIVE OF DILE TO (OR AS A CONSECUTIVE OF DILE TO (OR AS A CONSECUTIVE OF DILE TO (OR AS A CONSECUTIVE OF DILE TO (OR AS A CONSECUTIVE OF DILE TO (OR AS A CONSECUTIVE OF DILE TO (OR AS A CONSE | Q DUENCE OF: | | | indrome 10 years |
| shows any injury, : MEDICAL C | CMV retinitis | contributing to deeth but not r | esulting in the underlyle | ng ceuse given in i | Part I. 24a. WAS AN PERFOR | MED? AVAILABLE PRIOR TO |
| item 23 SICIAN | | | E OF DEATH (Check only one OTHER: | | | |
| marked, or BY PHYS | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 28c. IN W | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW IN | NJURY OCCURED |
| m 28 is ETED | 3 Suicide 6 Could not be determined | 28s. PLACE OF INJURY — At ho building, etc. (Specify) | | | City or Town, State) | nd Number or Rural Route Number, |
| = 5 | | N: To the best of my knowledge, de On the bests of examination and/or i | | | | ner as stated, d dus to the cause(s) and manner as stated, |
| IMPORTANT. | 296. SAGNANURE AND TITLE OF CENTIFIER 10. NAME AND ADDRESS OF BERSON WAYS | | | M 40 8 | | 29d. DATE SIGNED (Month, Day, Year) August 29,1995 |

| le | - 8 | VC | | _ | |
|-------|------------|------------|----|-------|----------------------|
| David | TOPIESS OF | PERSON WHO | MD | Johns | ATH (ITEM 27) (Type, |

CAUSE OF DEATH (ITEM 27) (Type, Print)
Johns Hopkins Bayview Medical 5200

31. DATE FILED (Month, Day, Year)
SEP 1 1 1995



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH TOSE PH 7:50 P. Edward MANUS 06 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Yea 1 M 2 - F DAYS HOURS 84 115-16-5596 -25 01 Mexico Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 5505 HAPKI'NS 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH JOHNS HOPKINS GER. CTR. DIRECTOR BACTIMORE BAYUIEW CIN C/7 Baltimore City RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard County Ellicott City permit. 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10e. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 2901 Pine Needle Dr. 21042 USA retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 N NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married Specify: WHITE BY 3 Wildowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5 +) 5 + Physician Private Practice 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname Joseph Macmanus H BE Elsa Sibbel notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Chris Macmanus Wellesley, MA 35 Colburn Rd. 02181 pe 20a. METNOD OF DISPOSITION

1 Burial 2 X Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Carroll Cremation, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 9 - 11Hampstead, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD completely filled in by the 21133 medical 23. PART I/Entar the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory arrest, ahock, or heart failure. List only one cause on each line. 6 IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition ementio event. resulting in death) Crem DUE TO (OR AS A CONSEQUENCE OF) prior to burial, traumatic CERTIFICATION and Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL signed by the ATNIAC FIBRICLATION CONGESTIVE any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? SELEURE DISOMPER MICHAG 1 - YES 2 - NO has been Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) tem certificate State HOSPITAL 1 TES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 X Nurs ng Home 5 Residence 6 Other (Specify) 6 the 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. OESCRIBE NOW INJURY OCCURED with 1. Natural м 1 YES 2 NO BY After 2 Accident 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 69 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after ditem 28 is ETED 8 Could not be 4 Nomicide determined hours 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. COMPL TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M (Check only one) MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occured at the time, data and place, end due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED/(Month, 2

5505 HOPKINS BAYVIEW CINCLE

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

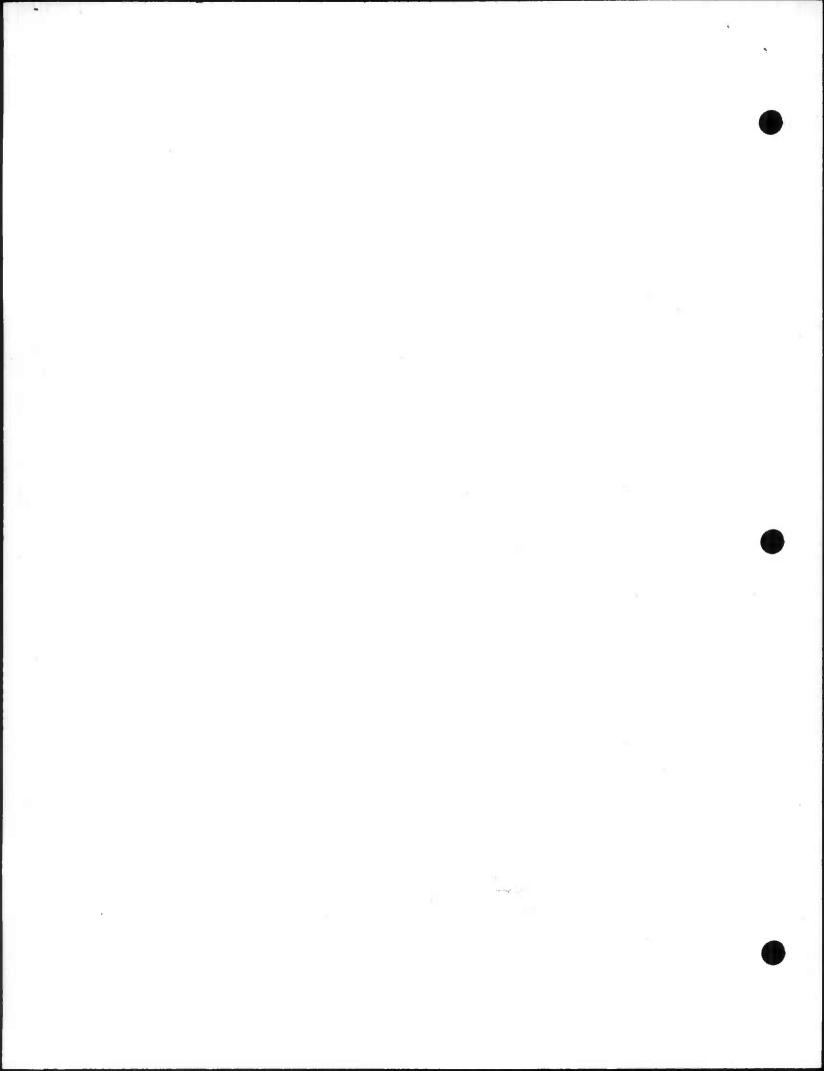
- JAGC

REGISTRAR'S IGNATURE

MI

dax

BACTIMONE



| CACHINGORY, MANICANO 21213-0020 | PHYSICIAN: The law regules that the death certificate be executed within 14 mount after death. Page 6 may be retained by the hospital or attending physician. | in certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Degr. or Health and Mental Highers prior to burial, cremation, or removal. | se medical examiner must be notified at once. |
|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within a | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compilerly filled in by the be filled within 72 froum after death with the State Dept. of Health and Mental Hygens prior to burist, cremation, or removal. | IMPORTANT: Il ham 28 is marked, or item 23 shows any lajury, or other traumable event, the medical examiner must be neitified at once. |

31. DATE FILED (Month, Day, Your)
SEP 1 1 1995

outh

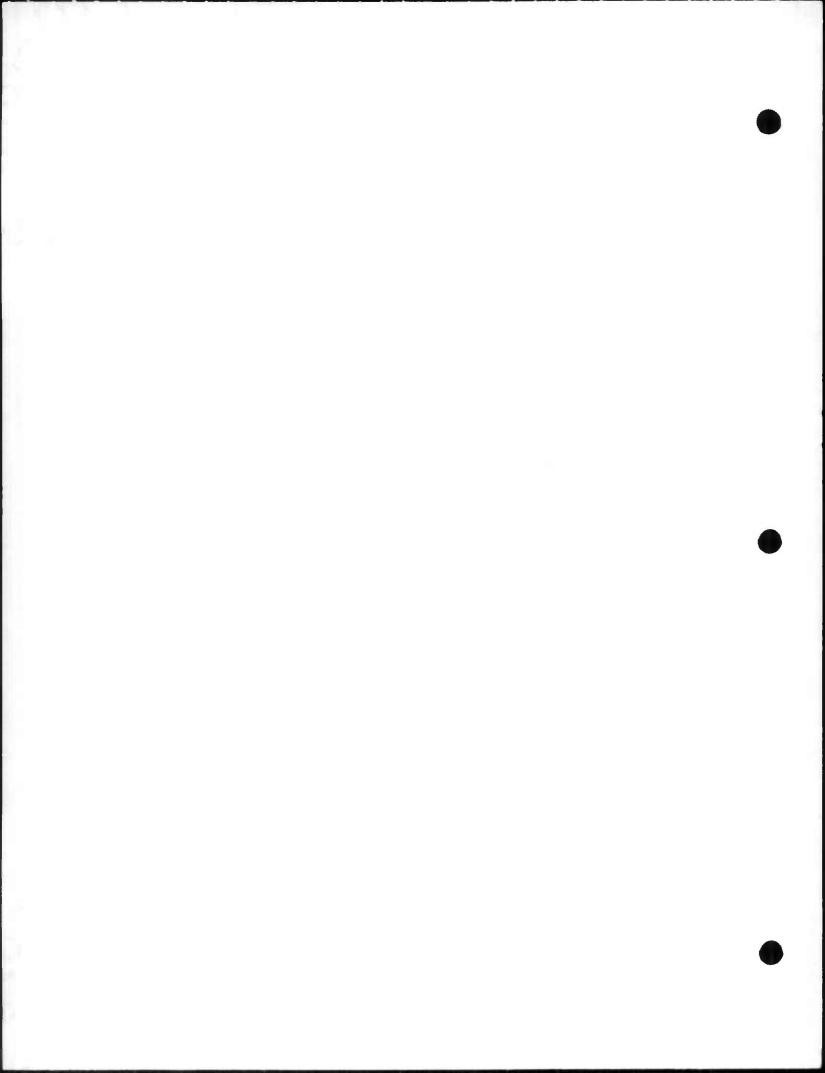
h Charles

32. RESISTRAND SIGNATURE RANGE

| | 1. DECEDENT'S NAME (First, ANNIN, Last) | | | | | | DEATH | 2. | REG. N | | | 3. TIME OF DEATH |
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| 1 | Catherine G. Ma | arsh | | | | | | Se | eptember | 10,19 | 995 | 9:00A |
| 1 | 4. SOCIAL SECURITY NUMBER | S. SEX | 6. AGE (In yes. i | The contract | # UNDE | DAYS | IF UNDER 24 H | A COLUMN TO SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE OF THE PERSON SERVICE STATE STATE OF THE PERSON SERVICE STATE STATE STATE STATE STATE STATE STATE STATE STATE STATE | DATE OF BIFTH (Month, Day, Year) | | ž. BIRTHI Courdy | PLACE (State or Foreig |
| - | 96. FACILITY NAME (If not institution, give: | 1 □ M 2 X□ F | 90 | YRS. | | | | | 12/7/19 | | | ryland |
| | 8588 Manorfiel | | | | | | H LOCATION O | F DEATH | | | TY OF DE | |
| | RESIDENCE OF DECEDENT | пвои п | | | ва | ltimo | ore | _ | | Balt | imor | .e |
| | 10a. STATE 10b. COUNT | | | 16c. CIT | Y, TOWN | OR LOCATION | ON | | | | \neg | 10d. INSIDE CITY LIMITS? |
| | MD B | Baltimore | | Ba. | ltim | | | | | | | 1 ☐ YES 2XX NO |
| | 19 Belhaven D | led up | | | | 101. | ZIP COO€ | | | 1000000 | | HAT COUNTRY? |
| | n. MARITAL STATUS | 17. WAS DECEDEN | CT FVFD W U.S. A | gwcn. | Te | WHO DECK | 2123 | | | | .S.A | |
| | 1 ☐ Never Married 2 ☐ Married 3 🐒 Widowed 4 ☐ Divorced | FORCES? 1 IF YES, GIVE V | AER 17 | (40 | | If yes, spec | city Cution, Mi 2 NO S | exicen, Pv | MIGIN? (Specify Y serto Rican, etc.) | es or No | | - American Indian, White, etc. White |
| | 15. DECEDENT'S EDU (Specify only highest grade | | | ECEDENT'S GAN Aind of | | | | | 16b, KIND OF 9 | USINEBS/INDI | USTWY | Discourage of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Con |
| | Elementary/Secondary (0-12) | College (1-4 or 8 | - 4 | No. Do NOT u | sur rutined.) | | | | HEATT AND A SEC. | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | Packe | er- | | | | | le Fac | tory | |
| ı | John Long | | | | | | | | First, Middle, Melde | n Surname) | | |
| ı | TRE. INFORMANT'S NAME (Type/Print) | | Τ, | Sb. MAILING | ADDRES | S (Street an | | | ickerts | non State Vin | Cooke | |
| ı | June Dapkunas | | | | | | | | imore, N | | | 1226 |
| | 21. SIGNATURE OF FUNDINAL SERVICE L | Pap | bellin | 0111 | 71 | 110 B | elair | Road | The Di | MD21: | Fune: | MD. ral Home |
| | 21. SIGNATURE OF FUNDAL SERVICE LI 23. PARTI. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | domplications the List only one day | ise on each life | LA CALLERON OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE | 71 The section | 110 B | elair de of dying, | Road | The Di | ppe1 1 MD21: | Fune: 206 | Approximate |
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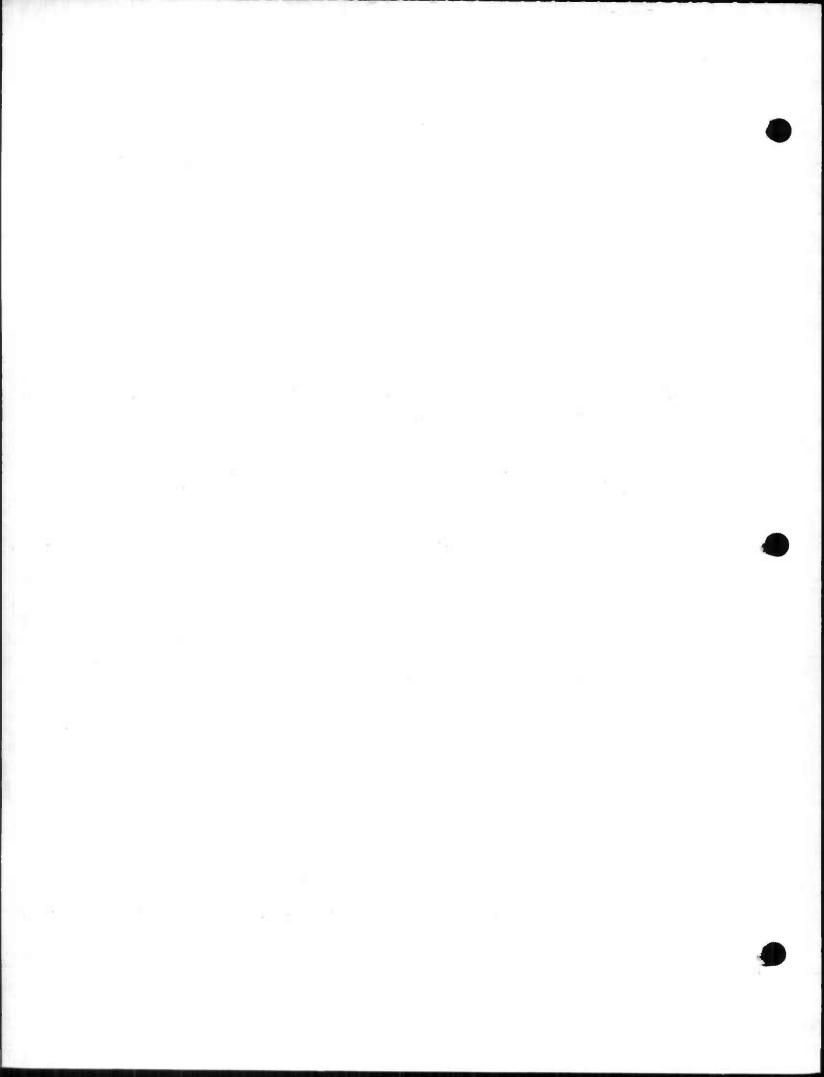
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without a flor death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

| • | 1 - STATE REGISTRAR | SIMIL OF IM | C | | | | DEATH | | REG. N | O. | | |
|---------------|------------------------------------------------------------|----------------------------|------------------------------|----------------------------|-----------------------------|----------------|--------------------------|---------------|-----------------------------------|----------------------|-----------------------|---------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) MARY F | MT. | LLER | | | | | M | ATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
| | Д. | | | | | | | \rightarrow | EPT. | 7, 1 | 995 | 7:15 P. M |
| | 4. SOCIAL SECURITY NUMBER | | 6. AGE (In yrs. II | | IF UNDER | 1 YEAR DAYS | IF UNDER 24 H | IN. (1 | ATE OF BIRTH Month, Day, Year) | | 8, BIRTHP Country) | LACE (State or Foreign |
| | 216-07-0452 | 1 - M 2X- F | 82 | YRS. | | | | | EPT.16, | | | YLAND |
| _ | 9e. FACILITY NAME (if not institution, give str | | | | | | R LOCATION O | OF DEATH | | 9c. CO | UNTY OF DEA | ATH |
| 5 | 227 S. GILMOR STR | EET | | | BA | LTIN | 10RE | | | В | ALTIM | ORE CITY |
| 2 | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | | 10c, CIT | Y, TOWN O | R LOCATI | ION | | | | T ₁ | IOd. INSIDE CITY |
| DIRECTOR | MARYLAND BAL | TIMORE C | TTY | | | RAT | TIMOR | F | | | | LIMITS? |
| | 10e. STREET AND NUMBER | TIMORE C | 111 | | | | ZIP CODE | E . | | 10a, CI | | IAT COUNTRY? |
| Ě | 227 S. GILMOR STR | EET | | | | | 212 | 23 | | | U.S.A. | |
| FUNERAL | 11. MARITAL STATUS | 12 WAS DECEDENT | EVER IN U.S. A | ARMED | 13, V | WAS DECI | | | RIGIN? (Specify | | 14. RACE - | - American Indian, |
| BY F | 1 Never Married 2 XMerried 3 Widowed 4 Divorced | FORCES? 1 | YES 2 X | NO | | | cify Cuben, M 2 XNO S | | erio Ricen, atc.) | | Black, Specify | White, stc. WHITE |
| a | 15. DECEDENT'S EDUC | ATION | | DECEDENT'S | | | | | 16b. KIND OF E | BUSINESS/II | NDUSTRY | |
| | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5 +) | - 4 | (Give kind of the Do NOT u | work done o se retired.) | during mos | st of working | | | | | |
| COMPLETED | 8TH GRADE | | | EAMSTE | RESS | | | | TA | ILORI | NG | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER | S NAME (F | irst, Middle, Maid | en Sumame) | | |
| | JOSEPH RICE | | | | | | MAI | RY | (UNK | (NWON | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | (Street s | nd Number or I | Rural Floute | Number, City or 1 | own, Stete, 2 | Zip Code) | |
| 2 | GILBERT G. MILLER | | 2 | 227 S. | . GIL | MOR | STREE! | r – E | ALTIMO | RE, M | D 212 | 223 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLAC | E AND DATE | OF DISPOS | ITION /Na | me of | | | | - City or Tow | n, State |
| | 1 Suriet 2 Cremation 3 Ramo | val from State | LOUDO | N PAF | RK CE | METE | ERY | 9 | /11 B | ALTIM | ORE | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 2 | | 22. 1 | NAME AN | D ADDRESS O | OF FACILITY | Y | TNG | | |
| | > M //2- | 0/20 | ٠) | | | | | | HOME, | | | |
| | 23. PART I. Enter the diseases, of c | omplications that | council the | death Do | | | | | NUE-BA | | | 21229 Approximate |
| | ahock, or heart failure. I | lat only one cau | se on each li | ne. | not enter | the mo | ue or aying, | SUCH ES | cardiac of re- | spiratory e | HTWS. | interval Between |
| - 1 | iMMEDIATE CAUSE (Final disease or condition | | 1.1 | | | * | | 1 | 1+ | | | Onset and Death |
| | resulting in death) | I | OR AS A CONS | A (| apo | 100 | ma, | mila | statue | | | 3 Min |
| _ | | 502 101 | ION AS A CONS | LOOENCE O | /F). | | | | | | | |
| CERTIFICATION | Sequentially list conditions, | DUE TO | (OR AS A CONS | EOUENCE O |)F): | | | | | | | + |
| A | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | DUE TO | (OR AS A CONS | EOUENCE O | OF): | - | | | | | | |
| E | resulting in death) LAST | 4 | | | | | | | | | | |
| | | | | | | | | | | | | |
| MEDICAL | PART II. Other significant conditions | _ , | | | | | g csuse give | n in Part | | AN AUTOPS FORMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 음 | AT heme | or disei | ore H | | upi | M | | | t 🗆 YES | 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| W. | | | | | | | | | | | | 1 YES 2 NO |
| | DID TOBACCO USE CONTR | LIBUTE TO CA | USE OF DE | ATH Y | ES 🔲 I | NO E | UNCER | TAIN [| | | | |
| 동 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PL | ACE OF DEA | OTHER | | | | | | | |
| Š | 1 □ YES 2 □ NO | 1 Inpatient 2 | ER/Outpatient | 3 DOA | | | e 5 🗆 Rasid | ence 8 🗆 | Other (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF (Month, Di | | 28b. TIR | ME OF | 28c. INJ WO | URY AT | 280 | . DESCRIBE HO | W INJURY C | CCURED | |
| BY | 1 Naturel 5 Pending 2 Accident Investigation | | | | М | 1 🗆 1 | res 2 N | 0 | | | | |
| | 3 Suicide 8 Could not be | | F INJURY — At etc. (Specify) | home, farm, | strest, lact | tory, offici | | 261 | LOCATION (Streetly or Town, St. | | ber or Rural Ro | oute Number, |
| | 4 Homicide determined | | | | | | | | _ | | | |
| PLE | 290. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of | my knowledge, | death occur | red at the t | lme, dete | end place, sn | d due to th | ne cause(e) and | manner se s | tated. | |
| COMPLETED | one) 2 MEDICAL EXAMINE | | | | | | | | | | | and menner ee stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENS | E NUMBER | | 29d D | ATE SIGNED | (Month, Day, Year) |
| 뭠 | James | 7 | MI | | | | | NOY | | ▶ | 9/0 | 190 |
| ၀ | 30. NAME AND ADDRESS OF PERSON WH | | | TEM 273 /3~ | a Print1 | | 1) | (| | | 1/8 | 21230 |
| | | | | | | 70 | 00 1140 | II T NI O II | יי דמ ווחם | D | DATES | |
| | DR. JAMES EVA | TAD - MAS | TITINGTUI | N VIL. | LAGE | - /(| JU WAS | ning. | TON RTA | ν., - | BALT. | IMUKE, MD |

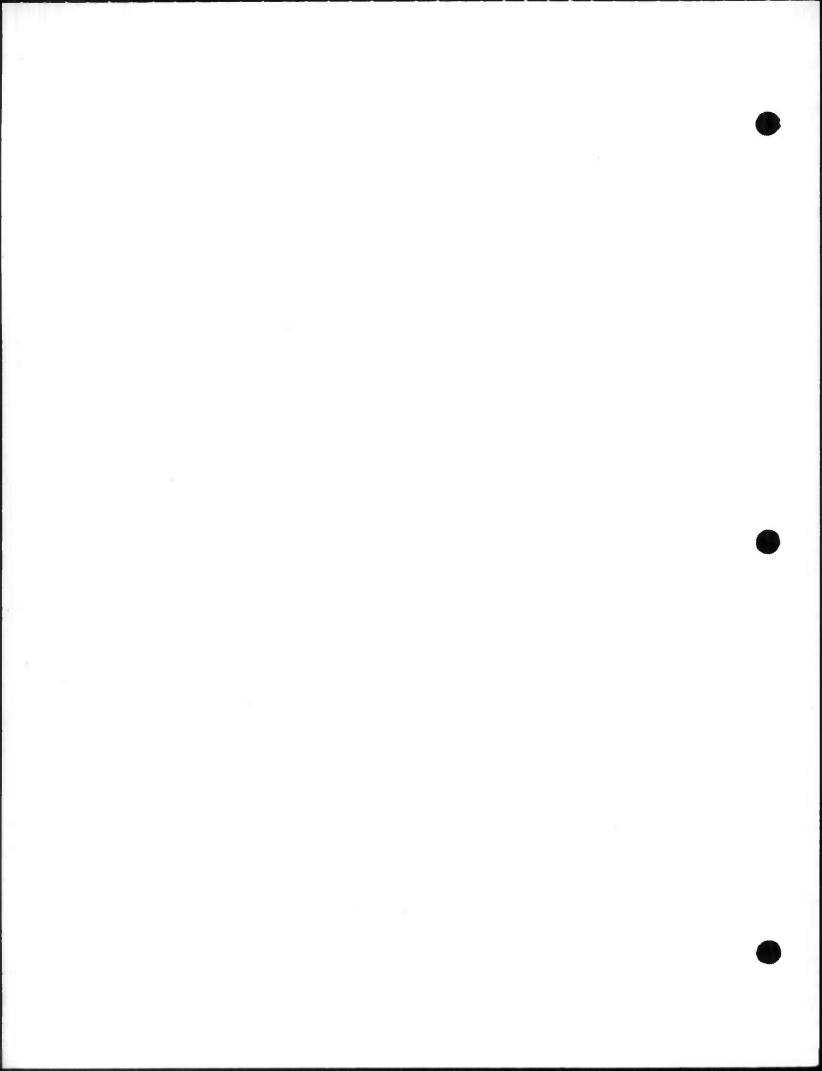


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| al examiner must be notified at once. | IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medic; TO BE COMDIFIED BY DEVOLUTION. MEDICAL CEDITICATION |
|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| al examiner must be notified at once. | IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should wal. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiens prior to burial, cremation, or removal. |
| ter death. Page 6 may be retained by the hospital or attending physician. | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
| | |

| STATE (| F MARYLAND / | | | | MENTAL | HYGIENE |
|---------|--------------|------------|---------|----|--------|----------|
| | C | ERTIFICATE | OF DEAT | TH | | REG. NO. |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH | | |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------|
| | 1. DECEOENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH | 3. TIME OF DEATH |
| | LOUIS MESSARIS | | , 1995 9:19 P |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 H | RS. 7. DATE OF BIFTH | 8. BIRTHPLACE (State or Foreign Country) |
| | 235-38-5207 1 M 2 🗆 F 68 YRS, MONTHS DAYS HOURS M | 3-27-192 | 27 West Virgini |
| ~ | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION C | OF DEATH | 9c. COUNTY OF DEATH |
| FUNERAL DIRECTOR | University of Md. Hospital Baltimore | 2 | Baltimore City |
| REC | 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY |
| ٥ | Maryland Baltimore Dundalk | | 1 YES 2 XNO |
| 3AL | 100. STREET AND NUMBER 101. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? |
| NE | 122 Kinship Rd. 21222 | | USA |
| FU | 1 X Never Married 2 Married POHCES? 1 AYES 2 NO If yes, specify Cuben, Me | SPANIC ORIGIN? (Specify Yes exican, Puerto Rican, etc.) | s or No— 14. RACE — American Indian, Black, White, etc. |
| ВУ | | pecify: | Specify: White |
| 60 | 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION | 16b, KIND OF BUS | SINESS/INDUSTRY |
| Ē | (Specify only highest grade completed) [Give kind of work done during most of working life, Do NOT use retired.] [Give kind of work one during most of working life, Do NOT use retired.] | | |
| 4P | 10 Roll Grinder | Beth - | - Steel |
| COMPLETED | | S NAME (First, Middle, Maiden | Sumame) |
| BE (| - | esa Bodi | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or R | | |
| | John Alawat 6603 Woods Pkwy. | | re, Md. 21222 |
| | 20e. METHOD OF DISPOSITION 1 | | CATION — City or Town, Blate |
| | 4 Donation 5 Other (Specify) Metro Crematory 21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS O | | tonsville, Md |
| | Connelly | Funeral He | ome of Dundalk |
| | | lers Point | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, shock, or hasrt fallure. List only one cause on each line. | such as cardiac or respi | ratory srrest, Approximats Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | Onset and Death |
| | s. Sepsis DUE TO (OR AS A CONSEQUENCE OF): | | |
| _ | Pneumonia | | |
| Ö | Sequentially list conditions, if any, isading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | |
| E | that initieted events DUE TO (OR AS A CONSEQUENCE OF): | | |
| CERTIFICATION | resulting in death) LAST | | |
| AL C | PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse giver | n In Part I. 24a. WAS AN | AUTOPSY 24b. WERE AUTOPSY FINDINGS |
| 2 | | PERFOR | IMED? AMPLIABLE PRIOR TO |
| | | 1 TES 2 | |
| - | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERT | TAIN DE | 1 TYES 2 NO |
| NA. | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | |
| SIC | EXAMINER? 1 YES 2 NO 1 No inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Resider | nce 8 Other (Specify) | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? | 28d. DESCRIBE HOW IN | NJURY OCCURED |
| BY | 1 Netural 5 Pending M 1 YES 2 NO | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 281. LOCATION (Street a City or Town, State) | and Number or Rural Route Number, |
| | | | |
| AP. | 29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and | due to the cause(s) and man | mer ee stated. |
| | one) 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occurred at | the time, date and place, and | d due to the cause(s) and menner as stated. |
| 8 | | | 29d. DATE SIGNED (Month, Day, Year) |
| SE COMPLETED | 29b. SIONATURE AND TITLE OF CERTIFIER 29c. LICENSE | | |
| H | Molly Burlon MD D469 | | ▶ 9/8/95 |
| | Molly Bus D D465 30. NAME AND AGORESS OF PERSON WILD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 536 | ▶ 9/8/95 |
| H | Molly Busles MD D465 30. NAME AND ACCRESS OF PERSON WED COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOlly Buzdon M.D. 22 S. Greene St. Balts | | ▶ 9/8/95 |
| H | Molly Bus D D465 30. NAME AND AGORESS OF PERSON WILD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 536 | ▶ 9/8/95 |



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| BOX |
| P.O. |
| RECORDS, |
| OF VITAL |
| DIVISION |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float her death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) Annette | e Meado | ows | 2. Date of Death MAUgust 279 1993 4:40 F | | | | | |
| | 577-16-1566 | 5. SEX 8. AGE (In yrs. lest birthday) 1 N 2 F 39 YRS. | MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 08-18-1956 0. BIRTHPLACE (State or Foreign Country) 0. District of Country | | | | | |
| TOR | Sa. FACILITY NAME (Il not institution, give stre Washington Advent RESIDENCE OF DECEDENT | | 96. CITY, TOWN OR LOCATION OF O | | ontgomery | | | | |
| DIRECTOR | | | ry, town on location | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 6500 Riggs Road | | 101. ZIP CODE 20783 | 10g, CI | CITIZEN OF WHAT COUNTRY? | | | | |
| В | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | | | | |
| COMPLETED | 15. DECEOENT'S EOUCA (Specify only highest grade co Elementary/Secondagy (0-12) | | B USUAL OCCUPATION work done during most of working ise retired.) | 16b. KINO OF BUSINESS/IF | NOUSTRY | | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NA | ME (First, Middle, Melden Surname) | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING | 3 ADDRESS (Street and Number or Rural | Route Number, City or Town, State, 2 | Sp Code) | | | | |
| | 20s. METHOD OF DISPOSITION 1 | al from State cemetary, crematory or o | | OATE 20c. LOCATION - | - City or Town, State | | | | |
| | 21. SIGNATURE OF UNERAL SERVICE LICEN | ASSEE Ronald Wade, Dir. | State Anacomy | | Baltimore Street 1 21201-1559 | | | | |
| | iMMEDIATE CAUSE (Final disease or condition | mplications that caused the deeth, Do et only one ceuee on each line. | not enter the mode of dying, suc | h ss cardiac or respiratory a | rrest, Approximats | | | | |
| ATION | immediate cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in dasth) LAST d. | DUE TO (OR AS A CONSEQUENCE O | AS A CONSEQUENCE OF): | | | | | | |
| PHYSICIAN, MEDICAL C | PART II Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | TH (Check only one) OTHER: | | | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. OATE OF INJURY 28b. TIM | A Nursing Home 5 Residence RE OF 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. OEŞCRIBE HOW INJURY O | CCUREO | | | | |
| 8 | 2 Accident 3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| COMPLET | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MIDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | |
| BE | END STUDIE AND THE OF ENTIFIED | andle | 29c. LICENSE NUM | WBER U 94. DA | TE SIGNED (Month, Day, Year) | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH (ITEM 27) (Type | , Print) | | - Y | | | | |
| | 31. DATE FILED (Morith, Day, Year) SEP11 1995 | 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | 1 - FOR STATE OF MARYLAND C | | MENT OF H | | MENTAL HYGIENI REG. NO. | | | | | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------|--------------------|----------------------------------------------------|-----------------------------|-----------------------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) CHARLES RICHARD MILLSAP | | | | | | 3. TIME OF OEATH 11:54 A M | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. le | | UNDER 1 YEAR | IF UNDER 24 HRS. | AUGUST 1. 7. DATE OF BIRTH (Month, Day, Year) | 8. E | BIRTHPLACE (State or Foreign | | | |
| | 217-72-6026 1 K M 2 🗆 F 30 | YRS. | NTHS DAYS | HOURS MIN. | 11-13-196 | | laryland | | | |
| ~ | the FACILITY NAME (If not institution, give street and number) | 98 | | R LOCATION OF DE | | 9c. COUNTY | OF DEATH | | | |
| 5 | 4903 BELAIR ROAD | | BALT | MORE C | ITY | | | | | |
| EC | 10e. STATE 10b. COUNTY | 10c. CITY, T | OWN OR LOCATI | ON | | 10d. INSIDE CITY LIMITS? | | | | |
| | Maryland | B | altimor | e. | | 1 X YES 2 NO | | | | |
| 3AL | 10e. STREET AND NUMBER | | 101. | ZIP CODE | | | OF WHAT COUNTRY? | | | |
| FUNERAL DIRECTOR | 3720 E. Northern Parkway | | T | 21206 | | u.s.A. | | | | |
| BY FU | 11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES | | | cify Cuban, Maxica | IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | | RACE — American Indian, Black, Whita, etc, Specify: White | | | |
| | 15. DECEDENT'S EDUCATION 18s. D (Specify only highest grade completed) | ECEDENT'S US | UAL OCCUPATIO | N t of working | 16b. KIND OF BUS | INESS/INDUST | RY | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | e. Do NOT use re | etired.) | | | | | | | |
| MP | 11 | tlec | trician | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Leat) Millsap | | | | ME (First, Middle, Malden | | ton Stinchcomb | | | |
| 8 | | Sh MAILING AT | ODESS (Street or | | Route Number, City or Town | | | | | |
| 2 | | | | | xay-Baltimo | | | | | |
| | 20a, METHOD OF DISPOSITION 20b. PLACE | | DISPOSITION (Na | | | CATION — City | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, | Dir. | | D ADDRESS OF FA | | | | | | |
| | Amount Allange | D (70. | | | | | timore Street | | | |
| - | 23. ART i. Enter the diseases, or complications that caused the d | leath. Do not | | | nore. Maryl | | | | | |
| | shock, or heart failure. List only one ceuse on eech lin IMMEDIATE CAUSE (Finel | 10. | | , | | , | Interval Between Onset and Death | | | |
| | disease or condition a. Hangen | EQUENCE OF: | | | | | | | | |
| z | C | | | | | | j | | | |
| 051 | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | |
| TIF | that initiated events DUE TO (OR AS A CONSEQUENCE OF): treaulting in death) LAST | | | | | | | | | |
| CEF | d. | | | | | | | | | |
| | PART II. Other aignificant conditions contributing to death but not | resulting in | the underlying | ceusa given in | Part I. 24e. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | |
| DIC | | | | | t YES 2 | SNO | COMPLETION OF CAUSE OF DEATH? | | | |
| MEDICAL | | | | | | | 1 NES 2 NO | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DIVINORMAN IN THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE | | | | | | | | | |
| 10 | EXAMINER? HOSPITAL: | CE OF DEATH | THER: | 37 | | | | | | |
| ΙλS | XXYES 2 NO 1 Inpetient 2 ER/Outpetient 27. MANNER OF DEATH 26s. DATE OF INJURY | 3 DOA 4 | | | 8 Other (Specify) | WINDA OCCUBI | FD | | | |
| | 1 Netural 5 Pending (Month, Day, Year) | 11 40 | Y WO | ES 2 PNO | Subject | Lynne | 1 self | | | |
| ВУ | 2 Accident Investigation 28s. PLACE OF INJURY — At I | | | 7 | 28f. LOCATION (Street a | and Number or F | Rural Route Number, | | | |
| TEC | | sidend | e | | 4903 Be | Lair K | ed Bulhmore | | | |
| J. | 29a. CERTIFIER (Check only Check only I CERTIFYING PHYSICIAN: To the best of my knowledge, | death occurred | at the time, data | and place, and due | | iner as atsted. | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the basis of examination and/o | | | | | | use(s) and manner as stated. | | | |
| ECC | 29b. SIGNATURE AND TIT LE-OF CERTIFI ER | | | 29c. LICENSE NU | MBER | | GNED (Month, Day, Year) | | | |
| 0 | O.C.M.E AUGUST 20. | | | | | | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT | | | et, Bal | timore, | Maryl | and 21201 | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | SEP11 1995 Julia Davidson Reveall | | | | | | | | | |

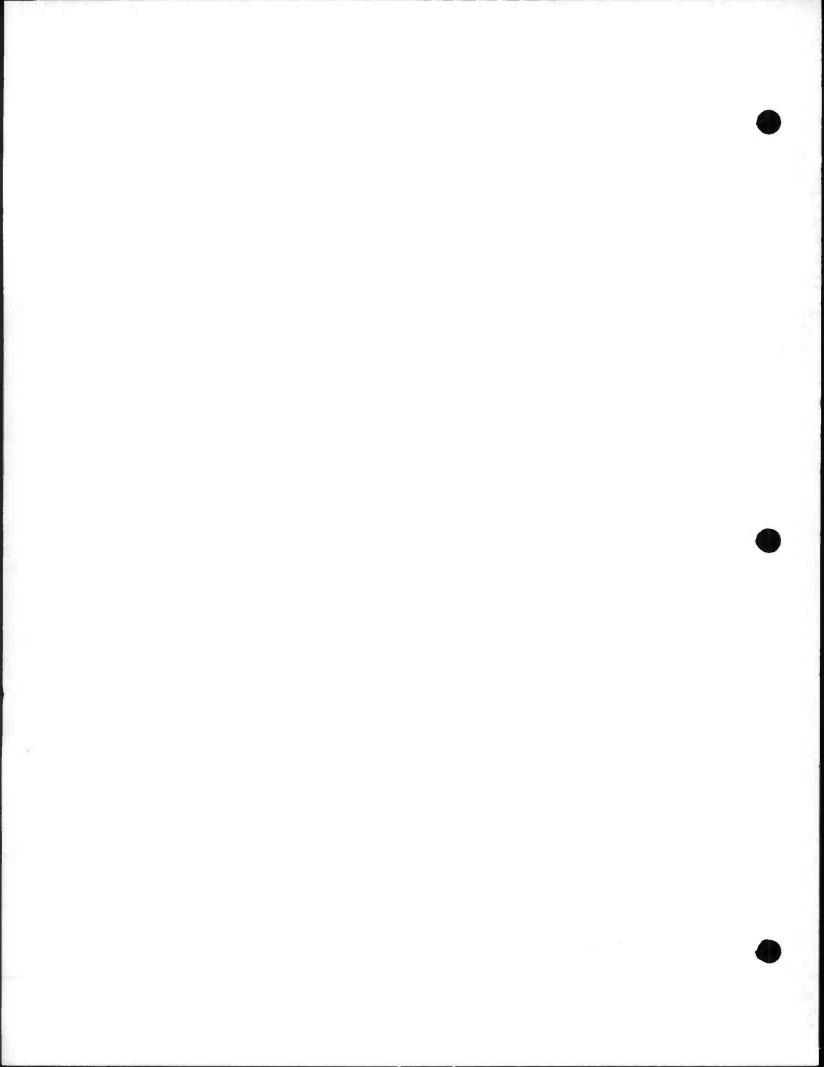
DIVISION OF VITAL RECORDS, P.O. BOX 68760

| STATE OF | MARYLAND / | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENE |
|----------|------------|------------|----|--------|-----|---------------|---------|

| | 1 - STATE REGISTRAR | STATE OF MARY! | | IENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------|-----------------------------|--------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | 0) | 0 | | 2. DATE OF DEATH 3. TIME OF DEATH | | | | |
| | SREAD | srael | OLI | PYEDE | September DAY | 2 /995 | 2310 1 | | |
| | 4. SOCIAL SECURITY NUMBER | 5. \$EX 6. AGE | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | UNDER 1 YEAR OF UNDER 24 HRS. | 7. DATE OF BIRTH | a. BIRTH Countr | IPLACE (State or Foreign | | |
| | 577-76-3518 | 1½ M 2 □ F 40 | YRS. | | (Month, Day, Year) 07-17-194 | 6 Nig | "eria | | |
| <u>ب</u> | 9e. FACILITY NAME (If not institution, give | | | CITY, TOWN OR LOCATION OF | | 9c. COUNTY OF D | | | |
| DIRECTOR | Shady Grove Adve | intest Hospeta | il 1 | Rockville | | Montgome | ry | | |
| မှု | 10a. STATE 10b. COUN | ITY | 10c. CITY, TO | OWN OR LOCATION | | | 10d. INSIDE CITY | | |
| <u> </u> | Maryland Mont | tgomery | Silve | er Spring | | | LIMITS? 1 YES 2 NO | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | 10g. CITIZEN OF W | VHAT COUNTRY? | | |
| ÿ | 3917 Castle Boul | | | 20904 | | | | | |
| 5 | 11. MARITAL STATUS 1 \(\bar{\chi} \) Never Merried 2 \(\bar{\chi} \) Merried | 12. WAS DECEDENT EVER I FORCES? 1 YES | 2 X NO | 13. WAS DECENDENT OF HISP If yee, specify Cuben, Mexi | | Black | — American Indian, c, White, etc. | | |
| à | 3 Widowed 4 Divorced | IF YES, OIVE WAR OR C | DATES | 1 TYES 2 X NO Spec | offy: | Specif | v: Black | | |
| 요 | t5. DECEDENT'S Et (Specify only highest gra | | 16a. DECEDENT'S USL | | 16b. KIND OF BUSH | NESS/INDUSTRY | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use re | done during most of working tired.) | | | 1 | | |
| M M | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S I | NAME (First, Middle, Maiden St | urneme) | | | |
| BE | 10a INFORMANT'S NAME/Tens/Drint | (Ariand) | | | | | | | |
| 2 | Edward Okwaghaw | fay (friend) | | ORESS (Street and Number or Rura | | | 1 00004 | | |
| | 20e. METHOD OF DISPOSITION | 201 | D. PLACE AND DATE OF D | ockett Lane-Si | | MAYUKA. ATION — City or To | | | |
| | 1 Donation 5 Other (Specify) | | metery, crematory or other | place) | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | ICENSEE Ronald Wa | ide, Dir. | State Anatomy | FACILITY PORT OF L | D = 0+1 | mata Cthaat | | |
| | Marcal 11 | 1 pool | | Rm. B026-Balti | | | | | |
| | 23. PART i. Enter the diseases, o | r complications that cause | d the deeth. Do not | enter the mode of dying, au | ich as cardlec or respire | etory arrest, | Approximete | | |
| | IMMEDIATE CAUSE (Final | e. List only one cause on a | each lina. | | | | intarval Between Onset and Death | | |
| | disease or condition resulting in death) | Pul | many | Dyretuson | | | over year | | |
| | | DUE TO (OR AS | A CONSEQUENCE OF): | 0 | | | | | |
| N N | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | rany, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events | C. DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| | resulting in death) LAST | d | | | | | | | |
| | PART ii. Other algolficant condition | ons contributing to death (| out not resulting in ti | he underlying cause given i | p Part i 240 MRS AN AI | ITTOREY 24h | WERE AUTORSY EINORIOS | | |
| SAL | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PROFORMED? AMILIABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | |
| | -01 | | | | 1 🗆 YES 2 | N NO | OF DEATH? | | |
| 2 | DID TOBACCO USE CON | TRIBUTE TO CAUSE (| OF DEATH YES | □ NO □ UNCERTA | MM | | TES 21 NO | | |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (| | | | | | |
| <u> </u> | 1 VES 2 NO | HOSPITAL: 1 A Inpatient 2 ER/Out | | FHER: ☐ Nursing Home 5 ☐ Reeldence | 8 Other (Specify) | | | | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | | 28d. DESCRIBE HOW INJ | JURY OCCURED | | | |
| βÁ | 1 Natural 5 Pending 2 Aboldent Investigation | | | M 1 YES 2 NO | | | | | |
| | 3 Suicide 6 Could not b | • 28e. PLACE OF INJURY building, etc. (Spe | f — Al home, term, stree city) | t, tectory, office | 28t. LOCATION (Street end City or Town, State) | d Number or Rural R | loute Number, | | |
| | 290. CERTIFIER | | | | | | | | |
| COMPLET | (Check only T CERTIFYING PHY | | | t the time, date and place, and do n my opinion, death occured at th | | | | | |
| ဗ ူ | 29b. SKIMASURE AND TITLE OF CERTIFI | | | | | | | | |
| H B | 290. SIGNATURE AND TITLE OF CENTIF | ~~ | | 29c. LICENSE N | UMBER : | 29d. DATE SIGNED | (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, Print | 10) | 0 1 1 | Spano | -1110 | | |
| | Dennis PriBOMA | | | Grove Rd, | Rockii de | and | | | |
| | SEPII 189 | 32 FRIGHTINGS SIGN | ar Rardall | / | | | | | |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH K. Colsen 1. SOCIAL SECURITY NUMBER 145 Am 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Morith, Day, Year, IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign YRS. 1 M 2 F permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH ROESSNET AUG 9c. COUNTY OF DEATH \ DIRECTOR Sh instran Hagerstown ma 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10909 Roessner Avenue 21740 been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transft. of Health and Mental Hygiene prior to burial, cremation, or removal. U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If was, apacify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. . BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Pu 1 YES 2 NO Specify: 1 Never Married 2 Merried BY 3 Widowed 4 Divorced Specify White 16a. OECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) T BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Karen Davis 1730 Virginia Avenue-Hagerstown, Maryland 21740 must be 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremetton 3 Removal from State 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE 4 ℃ Donation 5 □ Other (Specify) H. BIONATUM OF INMERAL SERVICE LICENSEE Royald Wade; Dir. examiner 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition denocarcinoma resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY that shows any 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO has by Dept. UNCERTAIN . 23 OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) TO THE MOSPITAL OR ATTENDING PHYSICIAN; The TO THE FUNERAL DIRECTOR: After this certificate I be filed writhin 72 hours after death with the State IMPORTANT; If Nem 28 is marked, or Nem HOSPITAL: OTHER: 1 | YES 2 1 Inpetient 2 ER/Outpetient 3 DOA 5 Residence 6 - Other (Specify) 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. (Check only one) mination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. 296. SIGNATUM AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 042915 BE 29d. DATE SIGNED (Month, Day, 2 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM, 27) (Type, Print) derson 31. DATE FILED (Month, Day, Year) SEP11 1995 A REGISTRAN SISIGNATORE



TO BE COMPLETED BY FUNERAL DIRECTOR

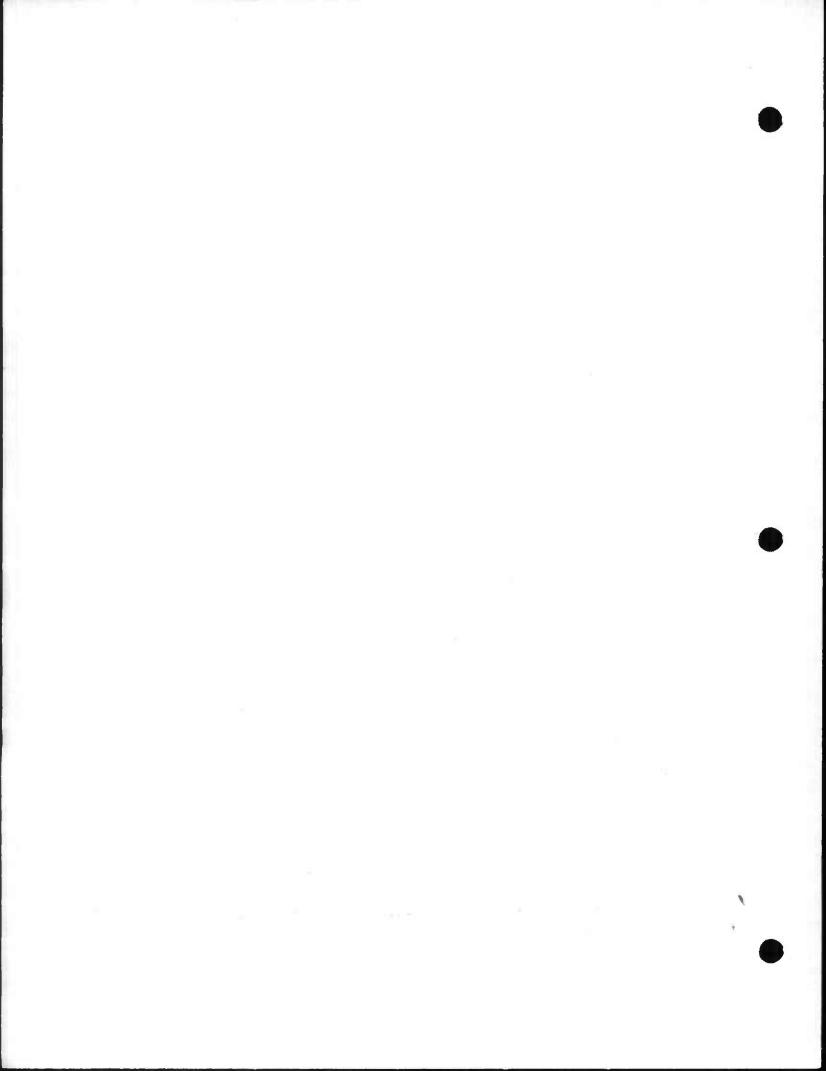
DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event the medical examinar must be notified at once. |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | 9 | 5 | 27379 |
|-----------------------------------------------------------------|--------------------------|------------------------------|------------------------------|-------------------------------------------|-----------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---------------------------------|--------------|-----------------|-----------------------------------------|
| 1 - FOR STATE REGISTRAR | | STATE OF M | IARYLAN | | | | EALTH AND | MENTA | L HYGIE | | | |
| 1. DECEDENT'S NAME (Firs | , Middle, Last) | A 1 | · · | | | | | | OF DEATH | | | 3. TIME OF DEATH |
| Larry | 1 | Maur | ae | . \ | 201 | ma | 3 | 5 e | in to | DAY | 995 | 6300 |
| | | | | rs. lest birthday) | (ay) IF UNDER 1 YEAR IF UNDER 24 HRS. | | | 7. DATE | | | | HPLACE (State or Foreign |
| 214-72-8456 1XM20F | | | | 36 YRS. | MONTHS | DAYS | HOURS MIN. | | th, Day, Year) | OFO | Coun | try) |
| Se. FACILITY NAME (If not in | _ | 30 | 9b. CI | TY, TOWN (| OR LOCATION OF D | | 17, 1 | - | Maryland COUNTY OF DEATH | | | |
| Joseph Rito | Joseph Ritchie Hospice | | | | | Ba | ltimore | | | | | /a |
| 10e. STATE | 10b. COUNTY | 1 | | 10c. CIT | ry, TOWN | OR LOCA | TION | | | | | 10d. INSIDE CITY |
| Maryland | | n/a | | | | -1-1- | | | | | | LIMITS? |
| 10e. STREET AND NUMBER | L | 11/ a | | | В | alti | L ZIP CODE | | | 10- 00 | 7175N OF | 1 VES 2 □ NO WHAT COUNTRY? |
| 022 til - L D. | | | | | | 1 " | 100 | | | iog. Cr | | WHAT COUNTRY? |
| 833 West Pi | att St | 12. WAS DECEDENT | F FVED IN II | 0.40450 | | | 21201 | | | | USA | |
| 1 Never Merried 2 | Married | FORCES? 1 | YES : | 2 XNO | 13 | If yes, sp | ENDENT OF HISPA ecify Cuban, Mexic | an, Puerto | N? (Specify Y Rican, etc.) | ee or No- | 14. RAC Blac | E — American Indian, ck, White, etc. |
| 3 Widowed 4 Dive | | IF YES, GIVE W | AR OR DATE | \$ | | 1 TYES | 2 NO Speci | Hy: | | | Spec | |
| 15. DEC | EDENT'S EDUC | CATION | 140 | a. DECEDENT'S | LIGHAL | 00011047 | | 1 | | | 1 | Black |
| (Specify on | y highest grade | completed) | | (Give kind of life. Do NOT u | work don | e durina ma | on ost of working | 160 | . KIND OF 8 | USINESS/IN | DUSTRY | |
| Elementary/Secondary (12th Grade |)-12) | College (1-4 or 5 + | | | | | 73.7 | Ι, | | 2.6 | | |
| 17. FATHER'S NAME (First, M | Valetta 1 aast | | | secreta | ту | OI R | adiology | | | 1 Center | | |
| | | | | | | | 16. MOTHER'S NA | | | n Surneme) | | |
| Gerald Palm | | | | | | | Al.ma | | | | | |
| 190. INFORMANT'S NAME (| ype/Print) | | | | | | and Number or Rural | | | | | |
| Alma Jones | | | | 833 West Pratt Street Baltimore, Maryland | | | | | | ryland 21201 | | |
| 20a METHOD OF DISPOSIT 1 A Burlel 2 Crematic 4 Donation 5 Other | (Specify) | 0 | cemeter | ACE AND DATE Ty, crematory or a 11awn (| ther place | terv | | se) | 5 Ba | ocation - | ore (| County MD |
| 21. SIGNATURE OF FUMERA | L SETTVICE LIC | Kollini | | | 2 | 501 (| Wynns Fanore, Ma | alls | itter | Fune | ral F | Homes, Inc. |
| 22 DADT : Enter the d | | amplications that | 5 | | В | altir | nore, Ma. | ry1.ar | nd 21 | 216_ | | |
| 23. PART t. Enter the d shock or h | aart fallure. | List only one caus | se on aech | e death. Do i ilina, | not ente | er the mo | de of dying, suc | ch ss csn | diec or rea | piratory s | rrest, | Approximate interval Between |
| IMMEDIATE CAUSE (FI | nel | | Λ | | | | | | | | | Onset and Death |
| disease or condition resulting in death) | → , | a | A | not | 0 | | | | | | | 24 hrs. |
| | | DUE TO | OR AS A CO | NSEQUENCE O | F): | | a. | | | | | |
| Sequentially list condit | lane C | Kne | moe | 511. | 5 | (ne | monie | - | | | | 1 mints |
| if sny, lesding to imme | diate | OUE TO | OF AS A CO | NSHQUENCE O | F): | | | | | | | 1- 0 |
| CAUSE (Disease or Inju | | / | 410 | | | | | | | | | 12 in my |
| that initiated events | | DUE 16 | OR AS A CO | NSEQUENCE O | SEQUENCE OF): | | | | | | | |
| resulting in death) LAS | | 1 | 671 | V+ | | | | | | | | Sin |
| PART II. Other significa | nt condition | s contributing to | death but | not requising | In the c | | and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | D. A.I. | | Ann Philipp | 1.0 | |
| | | | Jeen Dut | not resulting | m ure c | and erryrrig | g cause given in | Part I. | 24a. WAS A PERFO | RMEO? | 248 | AWAILABLE PRIOR TO |
| - | | | | | | | | | 1 TYES | 2 XNO | | OF DEATH? |
| | | | | | | | | | | , | | 1 - YES 2 - WO |
| DID TOBACCO U | | RIBUTE TO CAL | | | | | UNCERTAI | N 🔼 | | | | / |
| 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | 26. | PLACE OF DEA | | | | | | | | |
| 1 TYES 2 10 | | 1 Inpatient 2 | ER/Outpatie | nt 3 🗆 DOA | OTHE | | e 5 🗆 Residence | 6 K Othe | r (Specify) | Haz | piro | |
| 27. MANNER OF DEATH | | 26e. DATE OF 1 (Month, De | | 26b. TIM | E OF | 28c. INJ | URY AT | Y | SCRIBE HOW | INJURY O | CURED | |
| - | Pending Investigation | (month, De | y, rour) | IIN. | M | | RK? res 2 No | | | | | |
| 3 Suicide 6 | Could not be determined | 26e. PLACE OF building, a | INJURY — . itc. (Specify) | At home, ferm, | street, fe | ctory, office | | | ATION (Street or Town, State | | or Aurai | Route Number, |
| 29e. CERTIFIER | TFYING PHYSI | CIAN: To the best of r | Try knowledge | e deeth com- | ad pt sk- | tiene dat | and place and a | to the | made) - · | | | |
| | | | | | | | | | | | | e) and menner ee stated. |
| | | | | | , my | -pon, u | | | one piece, i | | - | 1 0 |
| 296. SIGNATURE AND TITLE | OF CERTIFIER | 1 | | 9 | | - 1 | 29c. LICENSE NUI | MIBER | | 294, DAT | E SONED | Month, Day, Ward |

Baltimae MD



| TO THE MOSPITAL OR ATTRONONG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be refained by the hospital or attending physician. |
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| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, should |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

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|---------------|----------------------------------------------------------|------------------------------|----------------------------|------------------------------------|-----------------|-------------|--------------|-------------------|-----------|-----------------------|-------------------------------|--------------|-------------|-------------------------------------------|------------|
| | FOR 1 STATE | | STATE OF N | MARYLAND / | DEPAR | TMEN | T OF H | IEALTH | AND I | MENTAL | HYGIEN | E | | | |
| | REGISTRAR | | | | ERTIF | | | | | | REG. NO | | | | |
| | 1. DECEDENT'S NAME (First, Mic | | | A 1 1 . | | | | | | 2. DATE O | F DEATH D | | YEAR | 3. TIME OF DEATH | |
| | RENAT | TO | P | ALLI | VII | | | | | SEP. | | | 195 | 1600 P | M |
| 1 | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. les | it birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE O | BIRTH | <u> </u> | O. BIRTHE | PLACE (State or Foreign | n |
| | 213-05-4838 | | 1 🔀 M 2 🗌 F | 87 | YRS. | MONTHS | DAYS | HOURS | SAIN. | Nov. | 27, | 1907 | Mar | yland | |
| | 9a. FACILITY NAME (If not institu | ition, give str | eet and number) | | | 9b. CIT | Y, TOWN C | R LOCATI | ON OF DE | | , | | ITY OF DE | 7 | |
| E E | Northwest Ho | spita | 1 Cent | er | | | Rani | dall: | stow | n | | | timo | | |
| 18 | RESIDENCE OF DECE | | | | | | ran | dalli | S C O W | | | Dal | . C IIIO | 716 | |
| DIRECTOR | | b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland | Carr | 011 | | | Syke | svil | le | | | | | | 1 YES 2 XNO | |
| A | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP COD | E | | | 10g. CITI | ZEN OF W | HAT COUNTRY? | |
| E | 7309 Second | Ave. | | | | | | 2178 | 84 | | | Uni | ted | States | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT C | OF HISPAN | IIC ORIGIN? | (Specify Yes | or No- | 14. RACE | - American Indian, | |
| BY F | 1 Never Married 2 Mar 3 Widowed 4 Divorced | | IF YES, GIVE W | YES 2 DA | 11.17 | - | 1 YES | | | n, Puerto Ric | en, atc.) | | Specify | , White, atc. | |
| | | | | u | JW 4 | - | | | | | | - 1 | | White | |
| TED | 15. DECEDE (Specify only hig | ENT'S EDUC. ghest grade o | ATION completed) | (G | CEDENT'S | work done | during mo: | N st of worldr | 10 | 16b. H | IND OF BUS | SINESS/IND | USTRY | | |
| <u>"</u> | Elementary/Secondary (0-12) | | College (1-4 or 5 + |) | . Do NOT us | , | | | | | | | | | |
| ₽ Z | 8th Grade | | | T | ailo | r | | | | M | iller | Brot | hers | <u> </u> | |
| COMPLET | 17. FATHER'S NAME (First, Middle | | | | | | | | | ME (First, Mic | | Sumame) | | | |
| BE | Salvatore Pa | | | | | | | An | giol | a Per | i | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/ | | | | | | | | | Route Number | | | | | |
| | Mr. Bob Cent | | i | | 6413 | Bon | nie l | Brae | Roa | d Sy | kesvi | 11e, | MD | 21784 | |
| | 20a, METHOD OF DISPOSITION 1 Devial 2 Cremation | | val from State | 20b. PLACE | | | | | _ | DATE | | CATION — | Sity or Tow | vn, State | |
| | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🔯 Other (Spi | | | Druid | Rid | | | | | 9/11 | | kesvi | | | |
| | 21. SIGNATURE OF FUNERAL SE | ERVICE LICE | INSEE - Ham | NB. C | rey | 1 22 | NAME AN | ID ADDRE | SS OF FA | CILITY ere - | 1 | 000 | Dul | · Ine | |
| | ► Variahin | VB. | 10les | 241) | | 0 | 607 | ing | | Reto | | | | 1133 | |
| | 23. PART I. Enter the disea | eses, Dr co | mplications that | caused the de | ath. Do r | ot ente | r the mo | da of dy | ing, auci | h aa cardie | c or reapi | ratory acr | eat. | Approximata | |
| | shock/or heart IMMEDIATE CAUSE (Final | t fallure. L | lat Dnly Dne cau | se on aach line | | 7 | | | | | | | | Interval Between Onset and De | |
| | disease or condition | | P | NEUN | 101 | JIF | A | | | | | | | 7 0AY | 1 8 |
| | resulting in death) | a | • | OR AS A CONSEC | | | , | | | | | | | 1001 | 3 |
| 2 | | | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions If any, leading to immediat | a, D. | DUE TO | OR AS A CONSEC | DUENCE OF | F): | | | | | | | | 1 | |
| 18 | cause. Enter UNDERLYING | | | | | | | | | | | | | | |
| | CAUSE (Disease Dr Injury that initieted events | 1 | DUE TO | OR AS A CONSEC | DUENCE O | F): | | | | | | 7 | | | |
| | reaulting in deeth) LAST | | | | | | | | | | | | | | |
| | DART II Other clearly and | | | | | | | | | | | | | | |
| <u>₹</u> | PART II. Other algoriticent of | | | | | | | ceuse | given in | Part I. 2 | 4a. WAS AN PERFOR | | | WERE AUTOPSY FINDIN AWAILABLE PRIOR TO | IGS |
| MEDICAL | | | | | | | | | | | YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? | Ε |
| | MIULTIPL | | | | | | | | | _ | | | | 1 [] YES 2 [] NO | |
| PHYSICIAN: | DID TOBACCO USE | CONTR | IBUTE TO CA | USE OF DEA | TH YE | S 🗆 | NO 🗆 | UNC | ERTAIN | 1 D | | | | | |
| 1 5 | 25. WAS CASE REFERRED TO ME EXAMINER? | | HOSPITAL: | 26. PLAC | E OF DEAT | OTHE | | | | | | | | | |
| YSI | 1 D YES 2 NO | | 1 Inpatient 2 | ER/Outpatient 3 | □ DOA | | | 5 □ Re | sidence | 6 🗆 Other (| Specify) | | | | |
| 표 | 27. MANNEB OF DEATH 1 Netural 5 Pers | 4 | 26a. DATE OF (Month, De | | 28b, TIM INJ | E OF URY | 28c. INJU | | | 28d. DEŞC | RIBE HOW II | NJURY OCC | URED | | |
| A | | estigation | | | | М | | 'ES 2 | NO | | | | | | |
| 8 | 3 Suicide a Coul | | 28e. PLACE Of building, | F INJURY — At ho etc. (Specify) | me, ferm, s | street, fec | tory, office | | | 28f. LOCAT City or | ION (Street a Town, State) | nd Number | or Rural Ac | oute Number, | |
| | 4 Hornicios one | rmined | | | | | | | | | | | | | |
| PL | 29a. CERTIFIER (Check only | ING PHYSIC | IAN: To the best of | my knowledge, de | ath occurre | d at the | time, date | and place. | and dua | to the cause | (a) and men | ner as state | id. | | |
| COMPLET | | | | | | | | | | | | | | and menner as stated | 1 . |
| Ü | 29b. SIGNATURE AND TITLE OF | | | | | <u>.</u> | | | ENSE NUN | | | | | (Month, Day, Year) | |
| 00 | 1((1) | K. | S.RAI | 1.17, C | 2 | | | - | | 46 | 2 | | | OS 199 | 15 |
| 2 | 30 NAME AND ADDRESS OF DE | | | | | | | <u> </u> | 7 3 | 40 | _ | / | | -0 -1 | |

CENTER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

(. S . R AD . T . D NORTH WEST HOSPITA K.S. RAD. M.D 32 SEGNTRAR'S CONSTURE

1995

RANDALLSTOWN

| 215-0020 | attending physician. |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

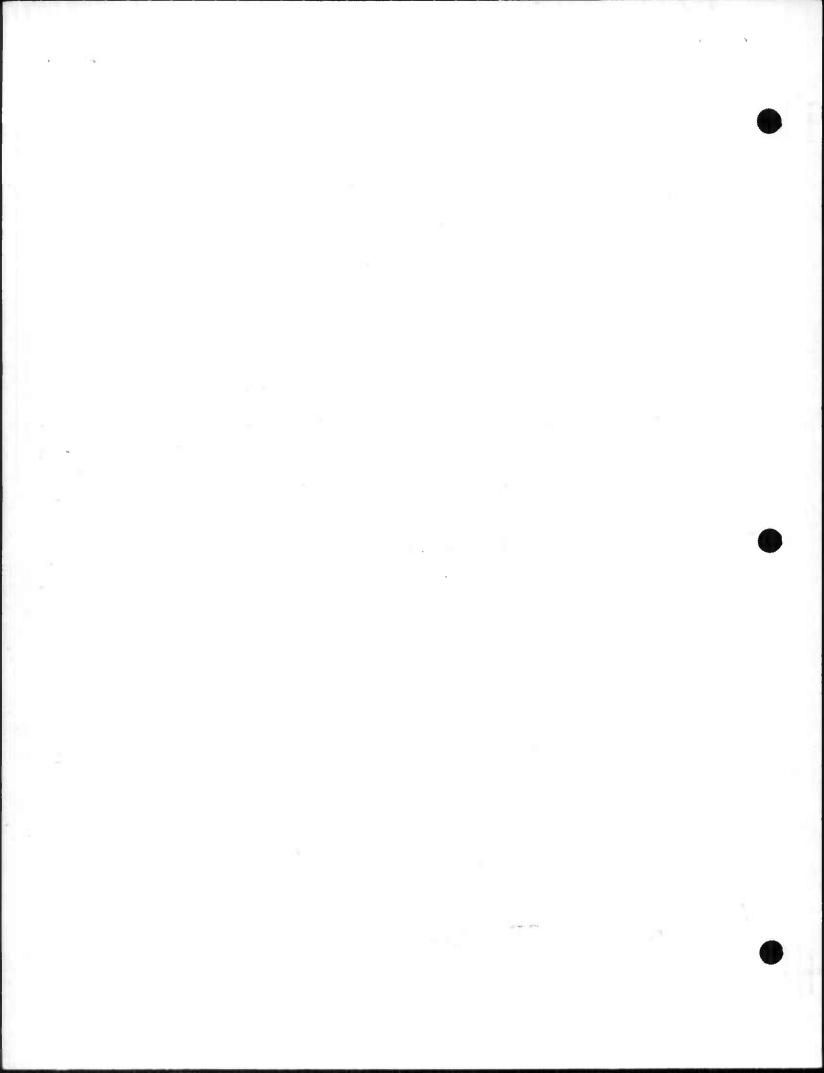
| BALLIMORE, MARTLAND 21213-0020 | Thousand the committee 6 may be retained by the hospital or attending physician, | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competing the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene print to burial, cremination, or removal. | e medical examiner must be notified at once. |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| CHARLES ON THE TECCHES, F.C. BOX 88/60 | TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate to executed within the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending plysicion and competed filed in by the it be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene parter to bursal, commanden, or remandal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| STATE | 0F | MARYLAND | / DEP | ARTMENT | 0F | HEALTH | AND | MENTAL | HYG | IEN |
|-------|----|----------|-------|---------|----|--------|-----|--------|------|-----|
| | | C | ERT | IFICATE | OF | DEAT | ГН | | REG. | NO. |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH A CERTIFICATE OF DEATH | | L HYGIENE REG. NO. | | | | | | | |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------|-----------------------------------------------------------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Leet) Miriam R. Rosensteel | | OF DEATH | 5 95° | 3. TIME OF DEATH | | | | | |
| | | ECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MONTHS DAYS MO | | | | | | | | |
| ron | 98. FACILITY NAME (If not Institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 1203 Staley Avenue 96. COUNTY OF DEATH Frederick Frederick | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Frederick 10c. CITY, TOWN OR LOCATION Frederick | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 1203 Staley Avenue 2170 | 1 | | F WHAT COUNTRY? | | | | | | |
| ВУ | | HISPANIC ORIGIN? (Specify Yes or No-Maxican, Puerto Rican, etc.) Specify: 14. RACE — American indian, Black, Whita, atc. Specify: White | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 166 | . KIND OF BUSIN | NESS/INDUSTRY | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER | ER'S NAME (First, | Middle, Meiden Su | urname) | | | | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Barry J. Kefauver (Son) 19b. MAILING ADDRESS (Street and Number or 8317 Cathedral Fo. | r Rurel Route Num Prest Dr | ber, City or Rown, | State, Zip Code) | tatign, VA. | | | | | |
| | 20s. METHOD OF DISPOSITION 1 General 2 Cremetlon 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION — City or Town, State | | | | | | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENSEE Ronald Wade, Dir. 22 NAME, AND ADDRESS State Anat Rm. 8026-Ba | | | | | | | | | |
| | 23. PAIT I. Enter the disease, or complications their caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition a. metastatic breast cancel resulting in death) | | | nory arreat, | Approximata Interval Between Onset and Daeth | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Metastatic breast councer | | | | | | | | | |
| | PART ii. Other aignificent conditions contributing to death but not resulting in the undarlying ceuse give | ven in Part i, | 24a. WAS AN AL PERFORMI 1 - YES 2 | ED? | 4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| PHYSICIAN: MEDICAL | | RTAIN | , | | OF DEATH? 1 □ YES 2 MNO | | | | | |
| YSICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 K NO NO NO NO 1 Input 1 Input 2 ER/Outpet 3 DOA 4 Nursing Home 5 K Reald | dence 8 🗆 Othe | r (Specify) | | | | | | | |
| ву РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 N | | SCRIBE HOW INJ | URY OCCURED | | | | | | |
| | 3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) | 201. LOC City | ATION (Street and or Town, State) | d Number or Rura | l Route Number, | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, are 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred | | | | e(s) and manner as stated. | | | | | |
| TO BE C | Sucaro musther D43 | SE NUMBER | 2 | ≥ 9/1/ | ED (Month, Day, Year) | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUSAN B. BRINKLEY, MD 915 Tollhouse Ave., Suit 31. DATE FILED (MORID, DON') 001 1005 | 203, 7 | REDERI | CK, ME | 21701 | | | | | |
| - 1 | 31. DATE FILED (MONTH), Day Joan 1905 | | | | | | | | | |

| DALLINORL, MARILANE | irs after death. Page 6 may be retained by the host | n by the funeral director, page 5 should be detache removal. | edical examiner must be notified at once. | |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Reath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

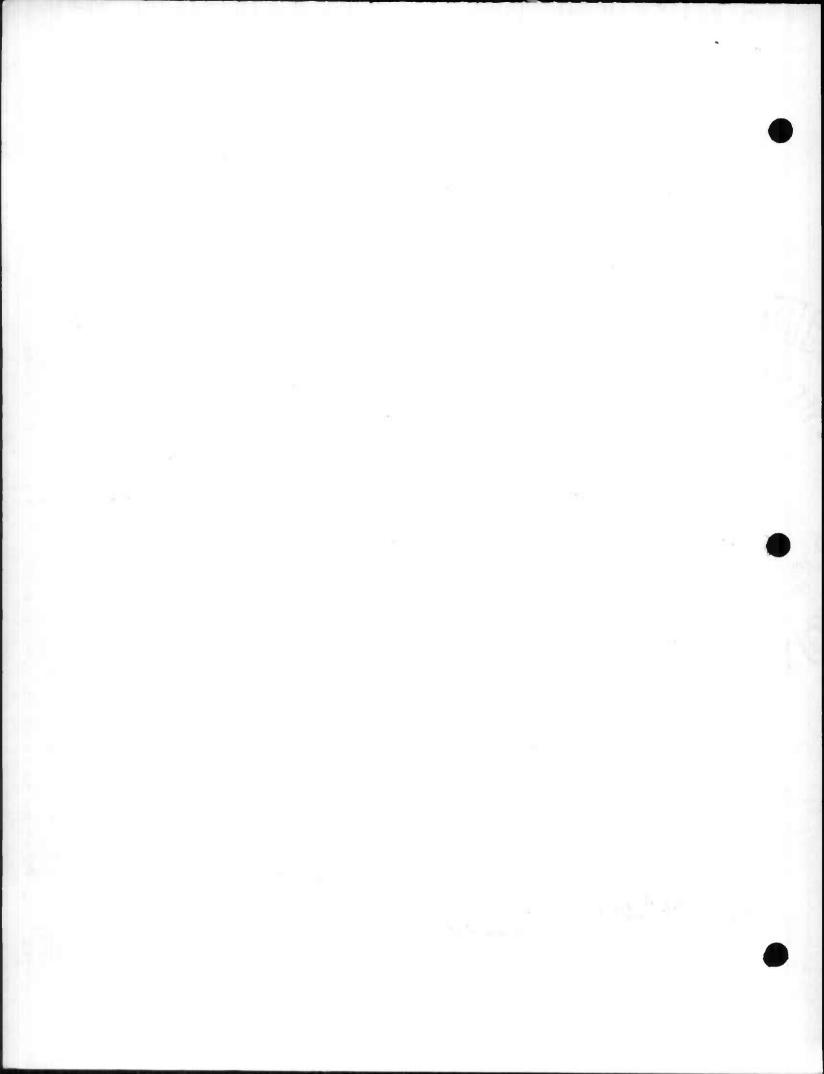
| | | | | | | J | 0 41002 |
|--------------|----------------------------------------------------------------------|--------------------------------|-------------------------------------------------|----------------------------------|-----------------------|--------------------------------|-------------------------------------------|
| | FOR 1 STATE | STATE OF MARYLAN | ID / DEPARTMI | NT OF HEALTH AND | MENTAL HY | GIENE | |
| | REGISTRAR | | CERTIFICA | TE OF DEATH | REC | . NO. | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 0 . | | 2. DATE OF OE | | 3. TIME OF DEATH |
| | SAMMIE | | 120 | 6 | Seokube | 09 199 | 5 6:45 P" |
| | | | | IDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIR | | BIRTHPLACE (State or Foreign |
| | 247-42-1636 | M2 DF 7 | YRS. MONT | HS DAYS HOURS MIN. | April 1 | 100 000 | Country) Babtimore, Maria |
| | 9a. FACILITY NAME (If not institution, give street | et and number) | 9b. | CITY, TOWN OR LOCATION OF C | | | Y OF DEATH |
| 2 | Mercy Mode | of Corde | . 2 | 11- | . / | 100 | 1 0:1. |
| 1 E | RESIDENCE OF DECEDENT | ac cenic | <u>v</u> 10 | altimore, T | any an | Dal | Mintore City |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOV | N OR LOCATION | | | 10d. INSIDE CITY |
| ā | Maryland Bal | Homore Cit | 4 B | Utmore | | | 1 APES 2 NO |
| 4 | 10e. STREET AND NUMBER | | 1 | 101. ZIP CODE | | 10g, CITIZE | N OF WHAT COUNTRY? |
| FUNERAL | 2200 PARK | Avenue - | Aut IE | 7121 | 7 | (| 15A |
| 2 | | 2. WAS DECEDENT EVER IN U | S ARMED | 13. WAS DECENOENT OF HISPA | NIC OBIGINS (Sans | the Year or No. 1 se | I. RACE — American Indian, |
| | 1 🔀 Never Married 2 🗌 Married | FORCES? 1 YES | 2 NO | If yes, specify Cuban, Maxic | en, Puerto Ricen, a | | Black, White, atc. |
| B | 3 Widowed 4 Divorced | IF TES, GIVE WAN ON OATE | 3 | 1 TYES 2 NO Speci | ity: | | Specify Black |
| | 15. DECEDENT'S EDUCA | TION 16 | A. DECEOENT'S USUA | L OCCUPATION | 166 KIND (| F BUSINESS/INDUS | |
| | (Specify only highest grade co | mpleted) College (1-4 or 5 +) | (Give kind of work di life. Do NOT use retin | one during most of working and.) | | | |
| 급 | // | College (14 or 51) | (100 | 1 | Pul | Il- T | 11/0 |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | 200 | 18 MOTHER'S N | AME (First, Middle, A | folder Supervision | VS |
| E C | | | 1, | | 2 0 | verberr Surneme) | |
| 00 | 19a. INFORMANZ'S NAME (Type/Print) | | 195 MAILING ADD | ESS (Street and Number or Rural | THO | | |
| 유 | may 1 | 1/2- | 2000 | Less (Street and Number of Hural | House Number, City | _ (| 000) |
| | 200, METHOD OF DISPOSITION | 1/6/ | DALO PH | TR AVE. HOLL | E DAM | imore) | mai 01217 |
| | 1 Buriel 2 Cremetion 3 Remove | | ACE AND DATE OF DIS | | CATE 2 | De. LOCATION — CH | y or Town, Stata |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN | ICEE | 1 6101 | L Lemi | 115 | 121110 | , Co, Ma |
| | C. STATE OF THE SERVICE EIGEN | | | 22. NAME AND ADDRESS OF R | LESS P | UNETA | 1 Home |
| | Yoseph L | · fless | | 2222 W.N | with Ar | P. BAIT | 5. God 21216 |
| | 23. PART i. Enter the diseases, or cor | mplications that caused th | e desth. Do not er | ter the mode of dying, suc | ch ss cardisc or | respiratory srres | t, Approximats |
| | shock, or heart fallure. Liz | it only one cause on each | i line. | | | | interval Batween Onset and Death |
| | disesse or condition | Pinarra | 0410 | | | | Oliset sind Death |
| | resulting in death) a. | DUE TO (OR AS A CO | | | | | |
| , | | Pulson | T | בייסרויר | | | |
| 0 | Sequentially list conditions, | DUE TO (OR AS A CO | | 310)() | | | |
| ¥ | if sny, leading to immedista cause. Enter UNDERLYING | | | | | | į |
| 윤 | CAUSE (Disease or injury that initiated svents | DUE TO (OR AS A CO | INSEQUENCE OF: | | | | |
| ERTIFICATION | resulting in death) LAST | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | j |
| 8 | 0. | | | | | | |
| | PART il. Other significant conditions | contributing to death but | not resulting in the | underlying cause given in | | AS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | ''' | RFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| l iii | | | | | '''' | | OF DEATH? |
| 5 | DID TOBACCO USE CONTRIB | BUTE TO CAUSE OF I | DEATH YES | NO UNCERTAL | МП | | TO TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 28 | PLACE OF DEATH (Ch | | ., . | | |
| S | EXAMINER? | OSPITAL: | | IER: | • C • u | | |
| ξļ | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME OF | Nursing Home S Residence | | OW INJURY OCCUP | 250 |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJURY | WORK? | 200. DESCRIBE | TOW INSURT OCCUP | NED . |
| B A | Accident Investigation | 28s. PLACE OF INJURY — | At home form street | | | | |
| 0 | 3 Suicide 8 Could not be 4 Homicide datarmined | building, etc. (Specify) | AI HOME, IEIM, STEEL, | sectory, office | City or Town, | Street and Number or State) | Rural Route Number, |
| iii i | 29a. CERTIFIER | | | | | | |
| AP. | (Check only CENTIFYING PHYSICIA | | | e time, data and place, and due | | | |
| COMPLET | 2 MEDICAL EXAMINER: | On the besis of axamination an | d/or investigation, in n | ry opinion, death occured at the | time, data and pla | ce, and due to the c | ause(a) and menner as stated. |
| ш | 296 SIGNATURE AND TITLE OF CERTIFIER | 011 | | 29c. LICENSE NU | MBER | 29d. DATE S | IGNED (Month, Day, Year) |
| 0 | I land the | Blake- | | Pno | 9124 | DS0- | b. 10 9 1000 |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | OMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Print) | | 461 | 1 Jep | Turner (1712) |
| | Dept. of Medicine | Marca Ma | elical Con | Her Buttimen | a Maria | and | |
| M | SEP1 1 1995 | ENISTRAR'S SIGNATU | RE | | 1 100 1071 | | |
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| cate be executed without 24 hours after death. Page 6 may be retained by the hospital or attending physician. | hysician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shoul | prior to burial, cremation, or removal. | ir traumatic event, the medical examiner must be notified at once. |
|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|
| N: The law requires that the death certificate be executed whim 24 hours after death. Page 6 may be retained by the hospital or attending phy | has been signed by the attending physician and completely filled in by the funeral director, page 5 sho | Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ir traumatic event, the medical exam |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The | TO THE FUNERAL DIRECTOR: After this certificate I | be filed within 72 hours after death with the State | IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other |

| FOR STATE REGISTRAR | STATE OF MAR | RYLAND / DEPARTI | MENT OF HE | ALTH AND N | | HYGIENE REG. NO. | | | |
|-------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------|-----------------------------|-----------------------|--------------------------------------|-------------------------------------|------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (Flost, Ogoi Sin | Middle, Last) -Rim | | | | 2. DATE OF MONTH Sept | . 9 19 | YEAR 95 | 3. TIME OF DEATH 7:20 A.M | |
| 4. SOCIAL SECURITY NUMB 218-92-6512 | M 1 □ M 2 🔀 F | 81 YRS. | | IF UNDER 24 HRS. HOURS MIN. | | 30,1914 | Kor | | |
| | Nursing Home | 9 | | location of de | ATH | | Ltimo | | |
| Chapel Hill RESIDENCE OF DEC | Baltimore | | ndallst | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| 3530 Cabot 11. MARITAL STATUS | Road | | 10f. | 21133 | | 10g. C/1 | Kore | VHAT COUNTRY? | |
| 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo | IF YES, GIVE WAR | YES 2 NO | If yes, spec | | n, Puerto Rici | Specify Yes or No— an, atc.) | 14. RACI Black | 14. RACE — American Indian, Black, White, atc. Specify: Asian | |
| 15. DEC (Specify only Elementary/Secondary (6 | EDENT'S EDUCATION by highest grade completed) 0-12) College (1-4 or 5+) | | rk done during most retired.) | of working | 16b. KI | ND OF BUSINESS/IN | | THE | |
| Unknown 17. FATHER'S NAME (First, M | 414-1-0 | Housew | ife | 40 1407145010 1444 | ME (Elma Adia | Own Home | 2 | | |
| Hwa Seung | | | | | n Dan | | | | |
| CO INFORMANT'S NAME (| | 19b. MAILING A | DDRESS (Street en | | | City or Town, Stete, Z | ip Code) | | |
| Mr. Jong Ba | e Rim | | | ad Rand | | | 2113 | 3 | |
| 20e. METHOD OF DISPOSIT (X) Burlet 2 Cremetic 4 Donation 5 Other | on 3 🗆 Removel from State | 20b. PLACE AND DATE OF cometery, crematory or other Lake View | DISPOSITION (Name place) | ne of | DATE | 20c. LOCATION - | City or To | wn, State | |
| 21. SIGNATURE OF UNERA | | O ATINGO | 22. NAME AND | Byers | Funer | al Direct | ors, | | |
| | b. ERE DUE TO (OR UNG) C. DUE TO (OR | | <u> </u> | NFAR | CTI. | O NO | R | Approximate Intervel Between Onset and Death H Mas | |
| PART II. Other elgolifica | | c Cardio | - Nasce | rlar Di | Seases | 44. WAS AN AUTOPSY PERFORMED? | 248 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| DID TOBACCO U | JSE CONTRIBUTE TO CAUS | | | UNCERTAIN | 4 D | | | | |
| 25. WAS CASE REFERRED TEXAMINER? | HOSPITAL: | | OTHER: | | | | | | |
| 1 YES 2 NO | 28e. DATE OF IN. | JURY 28h TIME | | 5 Residence | | Specify) RIBE HOW INJURY O | CCUBED | | |
| 1 Netural 5 D | Pending (Month, Day, | Year) INJU | M 1 V | | | | | | |
| | Could not be datermined 288. PLACE OF IF building, atc. | NJURY — At home, term, str . (Specify) | eet, factory, office | | City or | ION (Street and Numb Town, State) | er or Hurei | Houte Number, | |
| CONSCR ONLY | TIFYING PHYSICIAN: To the best of my | | | | | | | e) end menner ee stated. | |
| 296. SIGNATURE AND TITLE | | | | 29c. LICENSE NUI | | 29d. DA | | (Month, Day, Year) | |
| 30. NAME AND ADDRESS O | F PERSON WHO COMPLETED CAUSE | OF DEATH (ITEM 27) (Type, F | Print) | D1960 | | | | 9-95. | |
| R.M.St | 1AH. M.D. 107 | OG REIST | TERSTA | 1. inu | CM | . 21117 | | | |
| ST. DATE FILED (Month, Day SEP 1 1 19 | 95 Julia Diegostrania | GN TUTE | | | | | | | |



bunal-transit permit. Pages 1, 2, 3 should

physician.

D

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be completely mind the funeral director, page 5 should be completely within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at an

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21945-0020

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-727 9/16/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO. FOR 1 - STATE

| _ | HEGISTHAH CENTIFICATE OF DE | AITI | HEG. NO. | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------|-------------------|----------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Ann P. Lezama | | 2. DATE OF DEATH | 1 O O YEA | 3. TIME OF DEATH |
| | CHERYL RIVERA | | AUGUST | 1995 | |
| 1 | 121 - 51 - 5000 10 to to 120 MONTHS DAYS HOU | RS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | Co | RTHPLACE (State or Foreign |
| į. | 9e. FACILITY NAME (If not institution, give street end number) | | | 965 T | FINIDAD |
| <u> </u> | Landa WOODS | 11 1 | swn | | IMORE |
| 5 | RESIDENCE OF DECEDENT | 1,112 | 30077 | | 2110112 |
| DIREC | Mary AD Baltmore Randel | lstowi | U | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| ŧ. | 100. STREET AND NUMBER 19 Cimarron Circle / 13 101. ZIP C | CODE | _ | 10g. CITIZEN C | OF WHAT COUNTRY? |
| 5 | reimarron Circle 1 2 | 113. | 3 | US | FT |
| FUNERAL | | | C ORIGIN? (Specify Yes Puerto Rican, etc.) | | ACE — American Indian, llack, White, atc. |
| i i | 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 | | | S | Place /c |
| - 8 | 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION | | 16b. KIND OF BUS | INESS/INDUSTR | Y |
| ETED | (Specify only highest grade completed) (Give kind of work done during most of w | rorking | , | | |
| 7 | Elementary/Secondary (0-12) 12 5 Grade College (1-4 or 5+) Home make | | Own | Hon | 30 |
| 000 | | | E (First, Middle Maiden S | Sumame) | |
| | Stephen Martin LEZAMA | Yuun | INE RE | SCE | , |
| O BE | 190. JINFORMANT'S NAME (Type/Print) . 19b. MAILING ADDRESS (Street and No. | mber or Burni Ro | oute Number, City or Town | , State, Zip Code | , 105.13 |
| - | YUONNE LEZAMA P.O.Box 544 | Hov | rt Chest | w. No | w York |
| | 20e. METHOD OF DISPOSITION 1 | e terci | 90-15-99-100 | CATION - CHY O | or Town, State AIE Mary/AZ |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AD | | LITY <>> VO | REIS | Etstown Romo |
| 1 | dua- | n m - | llamis + | W. R. | It mer Mais |
| | 23. PART I. Enter the diseases, or complications that caused the dash. Do not enter the mode of | TICHT. | The first or most | 14 · KA | Approximate |
| | shock, or heart failure. List only one ceuse on each line. | dynig, addir | as cardiac or respin | atory arrest, | Interval Batwean Onset and Death |
| - 1 | IMMEDIATE CAUSE (Final disease or condition LIGATURE STRANGULATION | | | | Onset and Death |
| | resulting in death) a. ETGATURE STRANGOLATION DUE TO (OR AS A CONSEQUENCE OF): | | | | |
| _ | | | | | İ |
| CERTIFICATION | Sequentisity list conditions, If any, leading to immediate D. DUE TO (OR AS A CONSEQUENCE OF): | | | | |
| ¥ | cause. Enter UNDERLYING | | | | |
| | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | |
| | resulting in death) LAST | | | | |
| . 11 | PART il. Other significent conditions contributing to deeth but not resulting in the underlying cau | ree given in P | Part i. 24a, WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| 3 | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDICAL | | | 1 X YES 2 | _ MO | OF DEATH? |
| 3 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO U | INCERTAIN | īn l | | 1 YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | |
| 2 | EXAMINER? 1XXES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 | Residence 6 | X Xother (Specify) W | OODS | |
| PHYSICIAN: M | 27. MANNER OF DEATH 26s. DATE OF INJURY (\$9s. DIME OF 28c. INJURY) | | 28d. DESCRIBE HOW II | | 0 |
| | 1 Netural 5 Pending FOUND: 8-25-95 4:38 PM 1 YES | 2)() NO | SUBJECT STE | ANGLED | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not be 26s. PLACE OF INJURY — At home, farm, street, fectory, office building, ste. (Specify) | | 261. LOCATION (Street 4 | nd Nymber or Pi | CREAT NEAR LIBERTY |
| 2 | 4 (XHomiolde determined building, etc. (Specify) WOODED AREA | 1 | PLAZA SHOPPI | NG CENTE | R, RANDALLSTOWN, |
| | 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end | | | | |
| COMPLET | (Check only one) XX MEDICAL EXAMINER: On the besid of axamination end/or investigation, in my opinion, death | | | | use(e) and menner se stated. |
| 3 | | LICENSE NUMI | | | INED (Month, Day, Year) |
| BE | 290. SIGNATURE AND TITLE OF CERTIFIER | O.C.M | | ► AU | GUST 26, 1995 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED QUUSE OF DEATH (ITEM 27) (Type, Print) | | | | |
| | 111 Popp Street | Balt | imore, M | aryla | nd 21201 |
| | 31. DATE FILED (Morth), Dey, Wen 1995 SEP 1 1 1995 | | | | |
| Į. | SED 1 1999 March march 1 | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygines port to burial, correction, or entheir transmission or entheir and the marked or at fam 7 should be a fallen 2 shower and failure or other transmission are also account to the property of the property or other transmission and the marked or attended to the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the proper | |
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31. DATE FILED (MONT), DATE THE 1995

| | for 1 - STATE REGISTRAR | | | IARYLAND / | | TMENT | OF H | EALTH DEAT | AND M | | YGIENE EG. NO. | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------|-----------------------------------------|------------------------------------------|-----------------------------|------------------------------|--------------------|---------------------------------------|------------------------------|--------------------------------|-------------|-----------------------------------|--------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle & & & & & & & & & & & & & & & & & & & | lla, Lest) | | San | | (< | 2 | ma | | 2. DATE OF E | DAY | >O (| YEAR TO 3 | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 578-38-3902 | | M 2 🗆 F | 6. AGE (In yrs. las | t birthday) YRS. | IF UNDER | DAYS | IF UNDER | MIN. | | етн 5-192 | 2 | Country) | ACE (State or Foreign NGTON, DC |
| TOR | 98. FACILITY NAME (II not institute 8517 Hood Stre | let TAKO | | | | Six | rown | Spr | ing | TN | | Monte | gome | th Ly |
| DIRECTOR | 10a. STATE 10b. | county lontgom | ery | | 10c, CIT | y, town o | Sp/c | ion (11g | Silve | er Spr | ing | | | Dd. INSIDE CITY LIMITS? YES 2 NO |
| FUNERAL | 8517 Hood Stre | eet | | | | | 101 | ZIP CODI | 912 | | | 10g. CITIZI | | AT COUNTRY? |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Marris 3 Widowed 4 Divorced | ied F | MS DECEDENT ORCES? 1 YES, GIVE W W 11. US | | MED | - 1 | f yes, spe | ecify Cuba | F HISPANIC n, Mexican, Specify: | ORIGIN? (Sp Puerto Rican | pecify Yes or , etc.) | r No- 1 | H. RACE — Black, V Specify: | American Indian, White, etc. White |
| COMPLETED | (Specify only high Elementary/Secondary (0-12) | Colle | (1-4 or 5 + | (Gi | CEDENT'S the kind of the Do NOT us | work done (se retired.) | CCUPATIO | on st of workin | g | | S.A(RE | | | |
| BE CO | 17. FATNER'S NAME (First, Middle, MICHAEL HAMILTO | | V | | | | | | | E (First, Middle ETH ANN | | | | |
| 70 B | 19a. INFORMANT'S NAME (Type/Pr M. ANDREW DITVALL | | | | | | | | | ute Number, C | | | Code) | |
| | 20a. METHOD OF DISPOSITION 1 General 2 Cremation 3 4 Donation 5 Other (Spec | ☐ Ramoval fro | om Stata | 20b. PLACE A cemetery, cre | NDDATE | OF DISPOS ther place) | ITION (Na | me of | ALEX | DATE | 20c, LOCA | TION — CI | | , State |
| | 21. SIGNATURE OF FUNERAL SER UN OW 23. PART I. Enter the disease shock, pr heart is | ea, or compli | cations that | ceused the de | ath. Do r | S | tate n.B0 | Ana 26-B | altim | Board lore. | -655 Maryl | W. B | altir 2120 | nore Stree 01-1559 Approximate interval Between |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | Ø | cen | | 201 | | ושיו | fre | 1 | Haa | + | D | كمود | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | OR AS A CONSEC | | | | | | | | | | |
| MEDICAL C | PART if. Other algnificent co | onditiona cont | ributing to | deeth but not n | esuiting i | in the un | derlying | cause g | iven in P | | WAS AN AU PERFORME YES 2 | 07 | C | ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE DEATH? |
| | DID TOBACCO USE (25. WAS CASE REFERRED TO MED EXAMINER? | DICAL | | | TH YE | N (Check o | only one) | UNC | ERTAIN | | | | 1 | YES 2 NO |
| BY PHYSICIAN: | 1 DYES 2 NO 27. MANNER OF DEATN Natural 5 Pendin | 1 0 1 | PITAL: npetient 2 28a. DATE OF I (Month, De | | 28b. TIM | | Ing Home 28c. INJI WOI | JRY AT | 2 | Other (Spe | | URY OCCU | RED | |
| | 2 Accident Investor 3 Suicide 6 Could 4 Nomicide detarn | not be | ite. PLACE OF building, e | INJURY — At horide. (Specify) | ma, farm, s | street, facto | ory, office | 1 | 2 | Ref. LOCATION City or Tox | (Street and vn, State) | Number or | Rural Rout | e Number, |
| COMPLETE | | | | ny knowledge, dei amination and/or l | | | | | | | | | | nd menner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CO | ERTIFIER | 2 | 2- w | 0 | | | | NSE NUMBI | | | | | onth, Day, Year) |
| | 30. NAME AND ADDRESS OF PERS | SON WNO COM | PLETED CAUSI | E OF DEATH (ITEM | 1 27) (Type, | | 2 | 18 | 6 | , S Q | ns | im | Ac | do est |
| | SEPII | 1995 | 2 ANGISTRUM | S. SI SHATHIRA | dall | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING PHYSICIAN: The law requires that the death certificate be

permit. funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. 70 notified pe must examiner filled in by the fi medical the cremation, and completely event. prior to burial, traumatic the attending physician Mental Hygiene prior to Hygiene r 6 has been signed by t Dept. of Health and any Shows 23 this certificate h 0 marked. death After 28 is DIRECTOR: A F FUNERAL Dividition 72 hours TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH BEG NO ECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH SEWELL INCEN 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 5. SE) IF UNDER 24 HRS IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 7,1918 217-20-3615 1 M 2 F MONTHS DAYS HOURS MIN MARYLAND MAY YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BON SECOURS HOSPITAL N/A BALTIMORE RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2562 W. LAFAYETTE AVENUE 21215 21216 U.S. OF A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \times YES 2 \times NO IF YES, GIVE WAR OR DATES 9 \times 2 \times 4 3 \times 1 \times 2 6 \times 4 4 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14, RACE — American Indian, Black, White, atc. 1 Never Merried 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES NO Specify: BY 3 Widowed 4 Divorced BLACK 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET CONTRACTS ntary/Secondary (0-12) College (1-4 or 5+) N/A DISPATCHER BUILDING SUPPLIES 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) WILLIAM A. SEWELL FANNIE NAYLOR BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 MRS. NANNIE SEWELL 2562 W. LAFAYETTE AVE. BALTO., MD. 20a. METHOD OF DISPOSITION
t Burlat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 8/24/91) DATE 20c. LOCATION — City or Town, State BALTU GARRISON FOREST VET. CEM. OWINGS MILLS, MD. CO 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE LEWIS GWYNN | 22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME Lewis 4517 PARK HEIGHTS AVE. BALTO. MD. 23. PART I. Enter the diseesea, or complications that aused the deeth. Do not enter the mode of dying, auch as cerdiac or respiratory arreat, shock, or heart fellure. Liet only one ceute on each line. Interval Between IMMEDIATE CAUSE (Final Cell lung Cancer Onset and Death disease or condition_ resulting in death) CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL : OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 -DOA 4 Nursing Hame 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO В 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida COMPLETED 6 Could not be determined 29a, CERTIFIC CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner ea stated. MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner ea stated ERTIFIER BE 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print, 5. GREENE ST.

SO REGISTRAR'S SIGNATURE

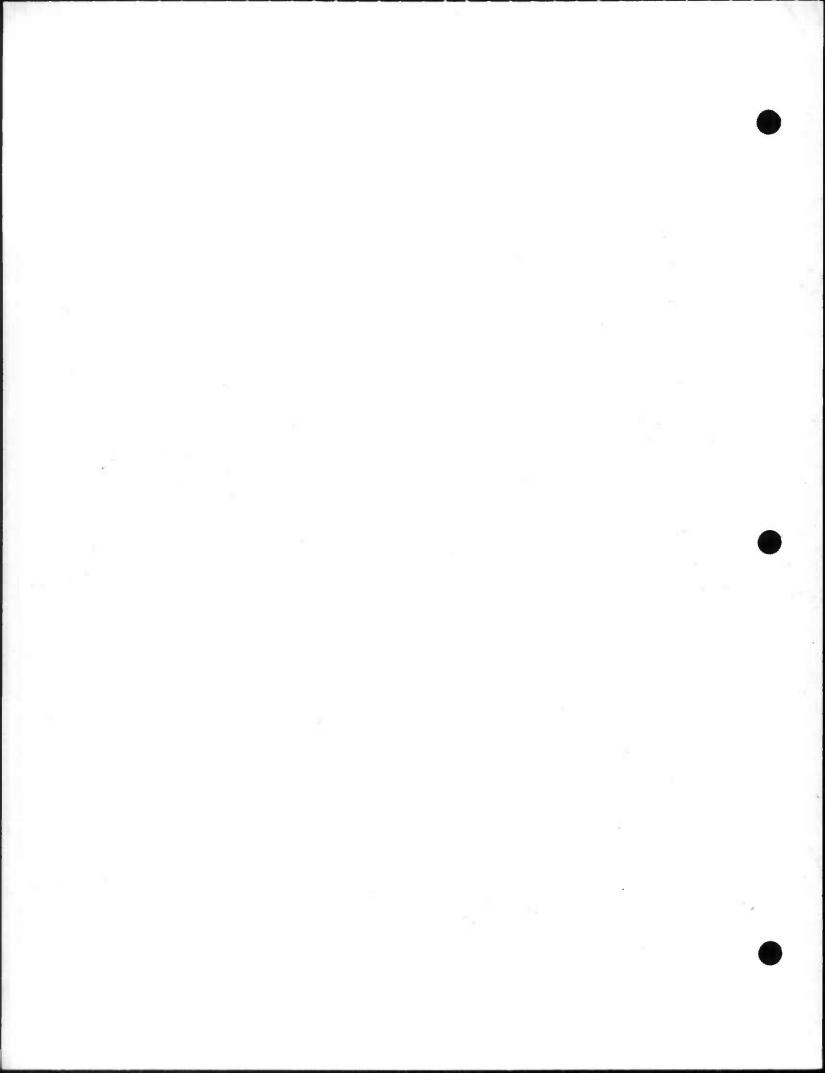
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DIVISION OF VITAL RECORDS, P.(

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MI | ENTAL HYGIENE |
|-------------------------------------------------|---------------|
| CERTIFICATE OF DEATH | REG. NO. |

| NATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEATH A STATE OF DEAT | | 1 - FOR STATE OF REGISTRAR | MARYLAI | ND / DEPAR | MENT OF H | EALTH AND | MENTAL HYGIENE REG. NO. | | | |
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| 8. SECT 1.991 19 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 | | MARY Henrietta | Wils | on | SAVAGE | | AUGUST 24 | 1995 | | |
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| 3 Suicide 4 Homicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, strast, factory, office 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and piace, and due to the ceuse(s) and manner as stated. 29b. SECHATURE ARD INTURE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30c. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31c. DATE FILED (Month, Day, Year) 31c. DATE FILED (Month, Day, Year) 31c. REGISTRAR'S SIGNATURE 31c. DATE FILED (Month, Day, Year) 31c. REGISTRAR'S SIGNATURE | | Alexander of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the | Day, Year) | INJU | RY WO | RK7 | 28d. DEŞCRIBE HOW INJU | IRY OCCURED | | - 1 |
| 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as ateted. 29a. SECRIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as ateted. 29a. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) A THE SIGNED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | - | NE IN HIEV | As been done of | | | | | | |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) August 24, 1995 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tony 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE) | 3 | o Could not be hullding | etc. (Specify) | At nome, term, st | real, rectory, offici | ' | City or Town, State) | Number or Rural R | loute Number, | |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) August 24, 1995 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tony 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE) | 4 | 20. CERTIFIER \ A | | | | | | | | _ |
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| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) August 24, 1995 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tony 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE) | בַּ ו | 2 MEDICAL EXAMINER: On the besis of a | xemination as | nd/or investigation | , in my opinion, d | eth occured at the | time, deta and piece, and de | us to the ceuse(e | end manner as state | d. |
| 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) John Grotto Johnston Kins Horgital 660 N Wolfe Street Batterier M 31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE) | | 296. SIGNATURE AND TITLE OF CENTIFIER | 1 | | | 29c. LICENSE NUI | ABER 21 | d. DATE SIGNED | (Month, Day, Year) | \neg |
| 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Girotto Johnston Kins Hongital 660 N Wolfe Sheet Bathnere, MI 31. DATE FILED (Morrith, Day, Year) 32. REGISTRAR'S SIGNATURE) | | ASTROMO ! | W. | | | M520 | 08 | Aumin | + 24 199 | 1 |
| | - | 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAU | SE OF OEATH | H (ITEM 27) (Type, I | Print) | | 1 | | | |
| | | John Gricotto | bhns | Hokns | Horisto | 0 660 | N Wolfe < | that | Batheres | NH |
| SEP 1 1 1995 Juli Studenterfell | | | AR'S SIGNATI | URE | 9 | | | 11000 | / | -4 |
| | | SEP 1 1 1995 Febrida | deerly | entally | | | | | | |



Approximata Interval Between **Onaet and Death** 12Yrs.

3. TIME OF DEATN

10d. INSIDE CITY VE YES 2 NO

8:14 A

PHYSICIAN: MEDICAL CERTIFICATION

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| | 1 STATE OF | MARYLAND / DEPAR | TMENT OF H | FAITH AND N | MENTAL HYGIEN | IF. | | |
| | 1 - REGISTRAR | | ICATE OF | | REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. | TIME OF DE |
| | John Henry Smith Jr. | | | | September | 8, 19 | 995 | 8:14 |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 8. AGE (in yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | - | CE (State or I |
| | 244-16-5762 1XM20F | 76 YRS. | MONTHS DAYS | HOURS MIN, | Month, Day, Year) | 1919 | Country) | NIC |
| | 9s. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN C | R LOCATION OF DE | ATH | 9c. COUNTY | Y OF DEATH | N |
| OR | Francis Scott K | 24 | BA | 140 | | A | 1/A | |
| 5 | RESIDENCE OF DECEDENT | | | -(0 | | | / - | |
| DIRECTOR | 10a. STATE 10b. COUNTY Balto | 10c. CIT | y, town or locat | 1 | ners St | ation | | I. INSIDE CIT LIMITS? |
| 7 | 10e. STREET AND NUMBER | | | ZIP CODE | 01. | 10a CITIZEI | | COUNTRY? |
| FUNERAL | 120 Chestn | ut St | | | 222 | 1 | J. S. | Α, |
| BY FU | 1 Never Merried 2 Married FORCES? 3 Wildward 4 Dispused IF YES, GIVE | T EVER IN U.S. ARMED I A YES 2 NO MAR OR DATES | 13. WAS DEC If yes, spe 1 — YES | cify Cuban, Mexican | | | Black, Wi | , |
| | 15. DECEDENT'S EDUCATION | NMIT | | | | | Diac | K |
| | (Specify only highest grade completed) | (Give kind of the life. Do NOT us | VSUAL OCCUPATION Work done during mos | N st of working | 16b. KIND OF BU | SINESS/INDUS | TRY | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 | ") Labo | | | Bethle | hem | Sta | rel |
| ш | 17. FATNER'S NAME (First, Middle, Last) John H. S. | mith, sr | | 18. MOTHER'S NAM | NE (First, Middle, Maiden | Surname) | | |
| 10 B | 19a, INFORMANT'S NAME (Type/Print) | 19b. MAILING | AODRESS (Street a | nd Number or Rural Re | oute Number, City or Tow | n, State, Zip Co | ode) | |
| ۲ | Judith L. Hill | 5824 | + Crow. | foot Dr. | , Burke | z, Va. | 22 | 2015 |
| | 20a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State | 20b. PLACE AND DATE of came jery, crematory or of | | me of | OATE 20c. LO | CATION - City | y or Town, | State |
| | 4 🗆 Donation 6 🗆 Other (Specify) | - CTARRI | | ST V. A. | 19/2 Ow | ins M | 112 | Md |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | D ADDRESS OF FAC | Mar ton | 5 | .a.c | |
| | 1 tomes a. | MANTE | Jam | | 100 | > 1/ | 1.3 | |
| | 23 PART I Enter the diseases or complications the | 1110000 | 1/01 | LAURE | | >A Itu. | MA | 212 |
| - 1 | 23. PART I. Enter the diseases, or complications the shock, or heart fellure. Liet only one car | et caused the death. Do r | ot enter the mo | de of dying, such | as cerdiec or respi | ratory arrest | t, | Approxin |
| | IMMEDIATE CAUSE (Final | | | | | | | Onaet an |
| ı | disease or condition a. Hyperte | nsive & Arte | rioscler | otic Card | liovascula | r Dise | ease | 12Yrs |
| ľ | DUE TO | (OR AS A CONSEQUENCE OF | F): | | | | | |
| Z | Sequentially list conditions, b. | | | | | | | |
| Ĕ | If any, leading to immediate | (OR AS A CONSEQUENCE OF | 7: | | | | | |
| 2 | cause, Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | |
| Ë | that initiated events resulting in death) LAST | (OR AS A CONSEQUENCE OF | F): | | | | | |
| CERTIFICATION | d | | | | 21. | | | |
| - 11 | PART ii. Other aignificent conditions contributing to | death but not resulting i | n the underlying | ceuse given in P | art 1. 24s. WAS AN | AUTOREV | 24h MITT | NE AUTOPSY I |
| DICAL | Chronic Obstructive Pulm | | | - July Biron III E | PERFOR | | AVA | LABLE PRIOR |
| | | | | | 1 _ YES 2 | K) NO | | DEATH? |

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗵 NO 🗌 UNCERTAIN [24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 N NO

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)

HOSPITAL: 1 Inpatient 2 DER/Outpatient 3 DOA OTHER: 1 TES 2 NO Home 5 Residence 6 Other (Specify) 27. MANNER OF GEATN 28a. DATE OF INJURY (Month, Day, Year) 25b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED

5 Pending investigation 1 XNatural 2 Accident 3 Sulcide Could not be

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) death occured at the time, data and place, and due to the cause(a) end manner as stated,

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

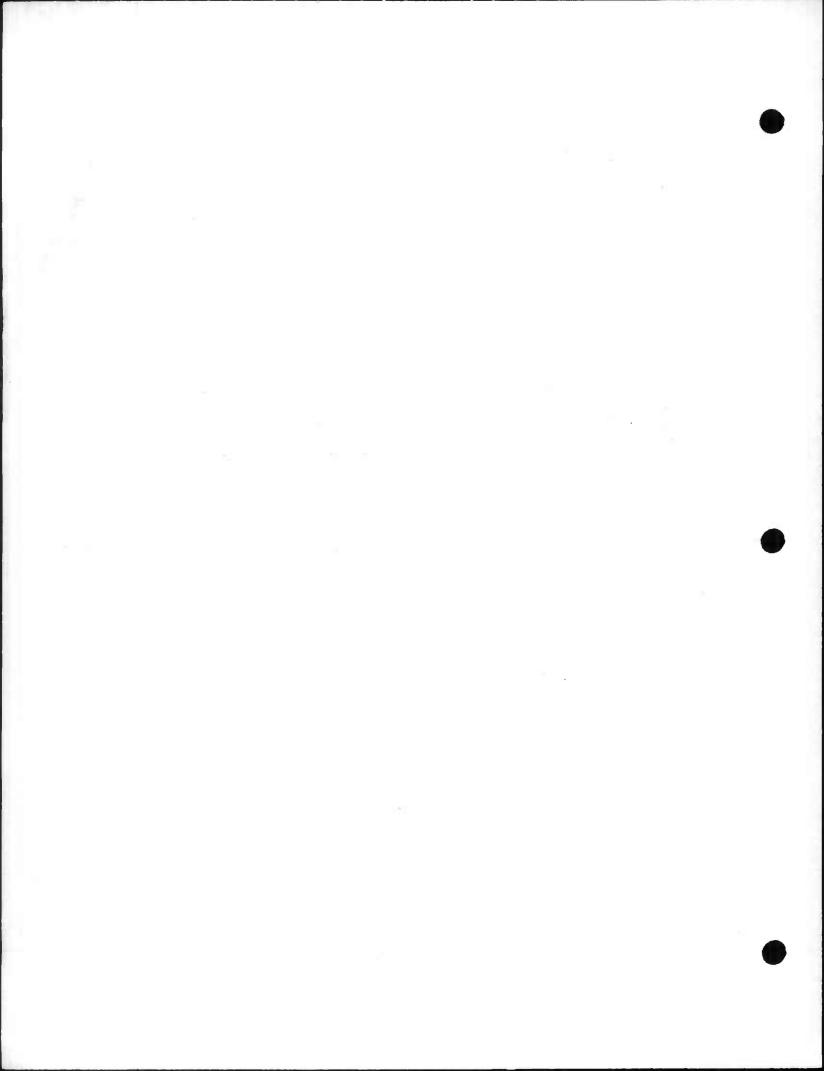
14852

29d. DATE SIGNED (Month, Day. 95

38. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type

Vadhana Claud
31. DATE FILED (Month, Day, Year) 9600 North Point Road. Fort Howard. MD 21052

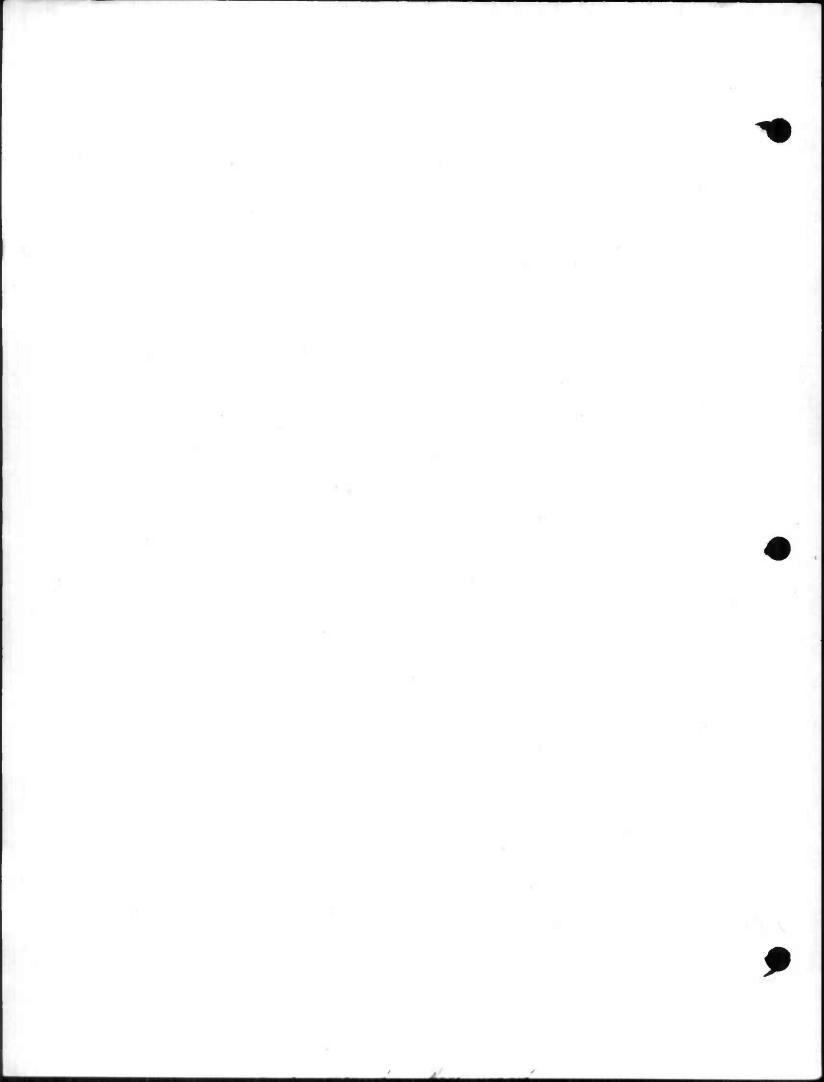
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| Stan he S | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate is TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physic be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene pric IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other tra | IAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | the formula been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | and Mental Hygiene prior to burial, cremation, or removal. | PORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Stan he S | Stan he S | at the death certificate be execut | by the attending physician and o | and Mental Hygiene prior to buri | y injury, or other traumatic |

| | 1 - FOR STATE REGISTRAR | TATE OF MARYLAN | ND / DEPARTM | | | MENTAL HYGIEN | E | |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------|--------------------------------|--------------------------------------------------|---------------------------|------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) REGINALD | HAROLD | SMALL | S | | 2. DATE OF DEATH DATE SEPT. 1 | , 1995 | 3. TIME OF DEATH 9:45 P M |
| | 220 01 0055 X |]Xn 3 □ F | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | JAN. 7, 1 | Cour | HPLACE (State or Foreign try) RYLAND |
| TOR | 98. FACILITY NAME (If not institution, give street or THE JOHNS HO RESIDENCE OF DECEMENT | | PITAL | | LT IMORE | CITY | sc. COUNTY OF | |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYLAND n/ | a | 10c. CITY, TO | OWN OR LOCATION | LTIMORE | | | 10d. INSIDE CITY LIMITS? XX YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 1610 N. AIS | QUITH STRE | ET | 101. | 21202 | | 10g. CITIZEN OF UNITED | WHAT COUNTRY? STATES |
| BY | 11. MARITAL STATUS 1 X Vever Married 2 Married 3 Wildowed 4 Divorced | MAS DECEDENT EVER IN U FORCES? 1 TYES F YES, GIVE WAR OR DATE | S. ARMED 2 X NO ES | | ify Cuben, Mexican | C ORIGIN? (Specify Yea), Puerto Ricen, etc.) | Bia | E — American Indian, ck, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled in the compiled | N (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (1000) 1 (| 6e. DECEDENT'S USU (Give kind of work We. Do NOT use ref ADMINIST | done during most lired.) | of working | | SECURITY | ADM. |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) HENRY SMALLS | | | | 18. MOTNER'S NAM CLARA | AE (First, Middle, Meiden DAVIS | Sumame) SMALLS | |
| 10 | JOYCE JOHNSON | POLLARD | 6019 | ARIZON | A AVENU | | ORE, MAR | YLAND 21206 |
| | 20s. METHOD OF DISPOSITION 1 ☐ Suriel 2 ☐X☐Menation 3 ☐ Removel in 4 ☐ Donation 5 Ø Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE | rom State commo | REENMOUNT | CEME 22. NAME AND | TERY S | 9+6 BA | LTIMORE, E. NORTH | MARYLAND |
| CERTIFICATION | 23. PARTY. Enter the diseases, or compliance, or heart failure. List of immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A C | ONSEQUENCE OF): L PAL ONSEQUENCE OF): L PAL ONSEQUENCE OF): ONSEQUENCE OF): | ng Di Disens | sease | as cardisc or respi | ratory srrest, | Approximate interval Batween Onset and Death Cour years |
| AL | PART II. Other algorificant conditions con | | | he underlying | | Part I. 24a. WAS AN PERFOR | RMED? | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBU | 26 | DEATH YES | | UNCERTAIN | 10 | | 1 - YES 2 NO |
| BY PHYSIC | EXAMINER? 1 YES 2 NO 1 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | SPITAL: Inputant 2 ER/Output 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | F 28c. INJU WOR M 1 Y | RY AT | 8 Other (Specify) 28d. DESCRIBE NOW I | NJURY OCCURED | |
| ED | 3 Suicida 8 Could not be 4 Homicide determined | 28a. PLACE OF INJURY — building, atc. (Specify | - At ho <i>m</i> e, lerm, atree) | t, lactory, offica | | 28f. LOCATION (Street a City or Town, State) | | Route Number, |
| COMPLET | one) 2 MEDICAL EXAMINER: On | To the best of my knowled the bests of examination a | | n my opinion, de | eth occured at the t | time, data and placa, an | nd due to the cause | |
| TO BE | 30. NAME AND ADDRESS OF PERSON WHO COM | Doctor MPLETED CAUSE OF DEAT | H (ITEM 27) (Type, Prin | 71) | N2558 | | > Septe | nber 1,1995 |
| | Karl How, no To | over 1055 | ohns ldge | kins l | bspitel | , Baltimor | e MD | |
| | SEP 1 1 1995 Julia | huther lands | 1 | | | | | |



mit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO BE COMPLETED BY FUNERA | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| examiner must be notified at once. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| e funeral director, page 5 should be detached for use as the burial-transit per al. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| death. Page 6 may be retained by the hospital or attending physician. | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
| | |

| | | 0 | 5 27390 |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH A CERTIFICATE OF DEATH | | |
| | 1. DECEDENT'S NAME (First, Middle, Lest) School Committee St. Sely 6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 | 2. DATE OF DEATH MONTH DAY O 8 2 7. DATE OF BIRTH (Morth, Day, Year) | 3. TIME OF DEATH 95 1/A M 8. BIRTHPLACE (State or Foreign Country) Maryland |
| AL DIRECTOR | Mericle Cronwell Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD Balto Balto MD 10c. CITY, TOWN OR LOCATION Balto MD 10d. STREET AND NUMBER | 21234 | 10d. INSIDE CITY LIMITS? 1 |
| BY FUNERAL | 8710 Errol Kd 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 PORCES? 1 YES 2 W NO 1 YES, GIVE WAR OR DATES 13. WAS DECENDENT OF IT YES, give war or DATES 14. WAS DECENDENT OF IT YES, give war or DATES 15. WAS DECENDENT OF IT YES, give war or DATES | HISPANIC ORIGIN? (Specify Yes or No Mexican, Puerto Rican, etc.) | U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: iv—Life |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentery/Secondary (0-12) College (1-4 or 5+) 1 2 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLUTA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER | 16b. KINO OF BUSINESS General Mo R'S NAME (First, Middle, Malden Surner | tors |
| TO BE C | 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or 3115 Fleet Street—200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of | Baltimore, Mary | |
| | 4X Donation 8 Other (Specify) The property of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pace of the pac | timore. Marulan | Baltimore Street d 21201-1559 |
| | 23. #ART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | Approximate Interval Between Onset and Desth |
| CERTIFICATION | Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inlitted events resulting in death) LAST | | Slas |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause give | en in Part I. 24s. WAS AN AUTOF PERFORMED? 1 YES 2 NO | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| PHYSICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Wursing Home 5 Residence (Month, Day, Year) 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY YORK? | | OCCURED |
| р Вү | Netural 5 Pending M 1 YES 2 P | 281. LOCATION (Street and Nu | mber or Rural Route Number, |

29d. DATE SIGNED (Month. 29c. LICENSE NUMBER

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

8 Could not be determined

1 CERTIFYING PHYSICIAN:

290. SIGNATURE AND TITLE OF GESTIFUE

31. DATE EILED (Month, Day, W

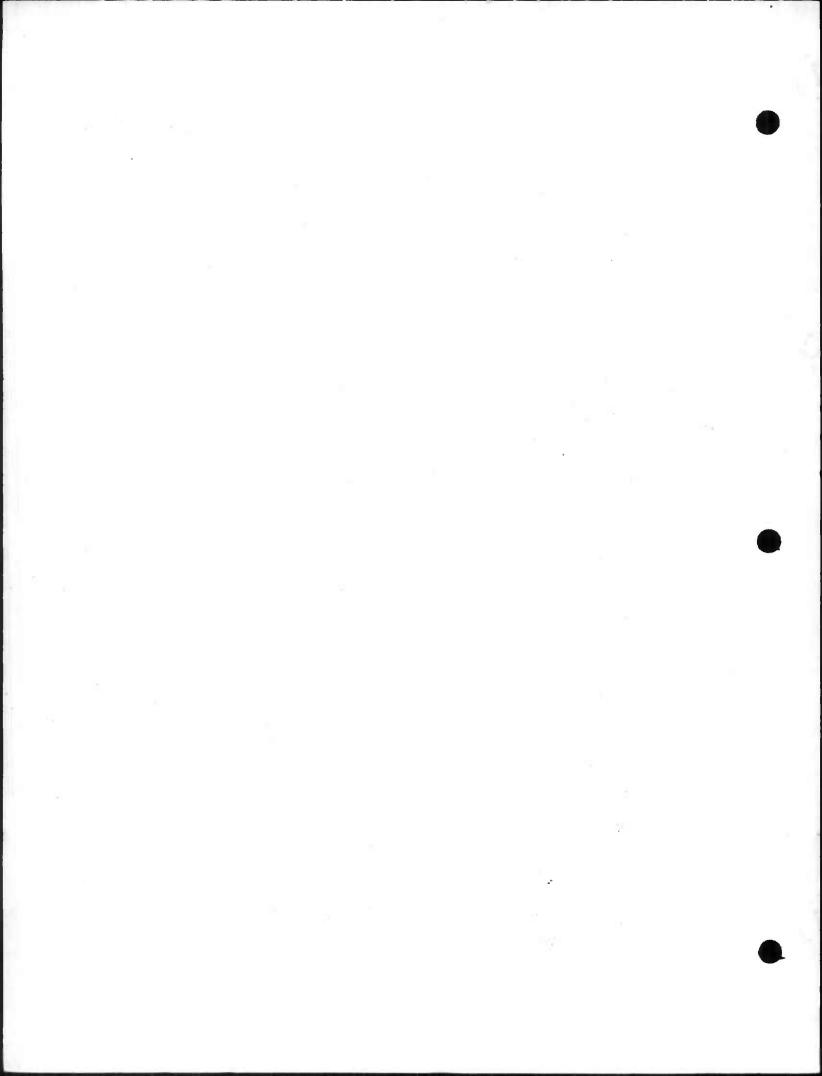
29a. CERTIFIER (Check only one)

RSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

2 N - W (for WW) - 3007 ENUMER

1 1995

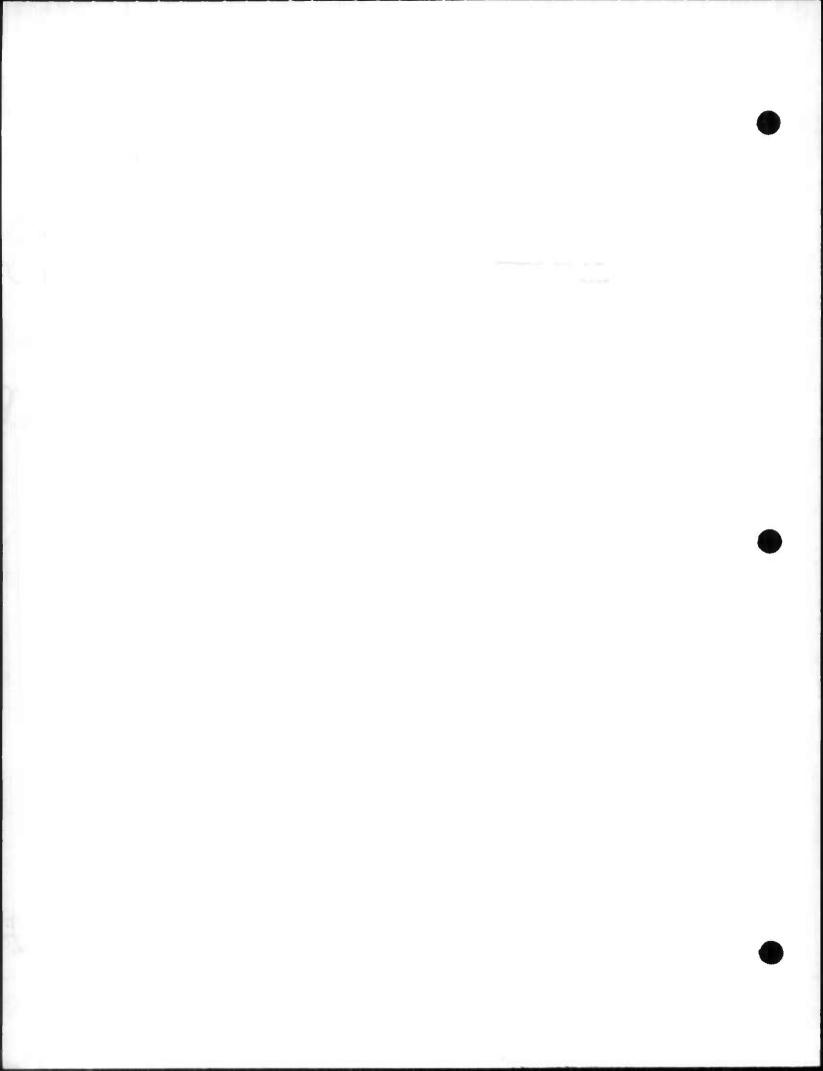
28e. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify)



| BALTIMORE, MARYLAND 21215-0020 | L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | . DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ţ | S IIII | etely fi |
| 3760 | rted wi | compl |
| 39 X | exect | n and |
| BO | ate be | ysicia |
| 0 | pertific | fing pl |
| 0 | death | attend |
| 3DS | t the | by the |
| 00 | es tha | peudi |
| RE | requi | S ueed |
| AL | he law | has t |
| VIT | AN: T | tificate |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | HYSICI | his cer |
| NO | ING P | Wher th |
| SIC | TEND | TOR: A |
| 7 | DR AT | DIREC |
| | _ | - |

permit. Pages 1, 2, 3 should TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requi TO THE FUNEAL DIRECTOR: After this certificate has been s be filed within 72 hours after death with the State Deot, of H

| | | | | , , , , | 201 1111 | | 70 | _ 1001 |
|-----------------------|-------------|----------------------------------------------------------|-------------------------------------------------------------------|---------------------------------|------------------------------------------------|----------------------------------------------|-----------------|-------------------------------------------------|
| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / D | EPARTMENT OF | HEALTH AND ME | | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) | 1 Mons. | TIFICATE OF | 2. | REG. NO. | YEAR | 3. TIME OF OEATH |
| | | 0,000 | | | | Jug 21 | 100= | 6:30Pm |
| | | A 10 22 A 101 | 8. AGE (In yrs. last bit | VRS. F UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. 7. HOURS MIN. | DATE OF BIRTH (Mouth, Day, Year) | | THPLACE (State or Foreign |
| | | 9e. FACILITY NAME (If not institution, give street | t and number) | 9b. CITY, TOWN | OR LOCATION OF DEATH | | e. COUNTY OF | PEATH |
| | DIRECTOR | LIBURTY ME | DICAL CENTE | 1 Ba | HIMUR | | N | (A |
| | E I | 10a. STATE 10b. COUNTY | - 1 | IOC. CITY, TOWN OR LOC | PATION | | | 10d. INSIDE CITY LIMITS? |
| | | laryland N | 7- | Bal | HMURE | | | 1 TES 2 NO |
| | FUNERAL | 104. STREET AND NUMBER DRUID | PARK DRIVE | , | 21217 | 1 | log. CITIZEN OF | WHAT COUNTRY? |
| | Š | 11. MARITAL STATUS | 2. WAS DECEDENT EVER IN U.S. ARMED | O 13. WAS D | ECENDENT OF HISPANIC | RIGIN? (Specify Vec.or | No I 14 BA | CE — American Indian, |
| | BY F | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, | specify Cuben, Mexican, Pr ES 2 NO Specify: | | Bio | ock, White, etc. |
| | E | 15. DECEDENT'S EDUCA' (Specify only highest grade co | | DENT'S USUAL OCCUPAT | TION | 16b. KIND OF BUSIN | E96/INDUSTRY | |
| | COMPLET | | College (1-4 or 5+) Iffe. Do | OME mal | | N | P | |
| at once. | NO. | 17. FATHER'S NAME (First, Middle, List) | 140 | 37.677001 | | First, Middle, Meiden Sui | mame) | |
| | BE | BELLON DE | NCET | | Conn | ic Spe | | |
| notified | ٩ | James (NES) | 196. M | AILING ADDRESS (Street | I and Number or Rural Route | Number, City or Town, S | 11. | MOVE Mary/m |
| st be | | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove | | DATEOFDISPOSITION | Name of | DATE 200 LOCAT | TION — City or | |
| E L | | 4 Donation 5 Other (Specify) | mt | LION CEL | neters 1 | Bay | Anda | Marylano |
| mine | - 8 | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE/ | 22. NAME | AND ADDRESS OF FACILIT | *5240 RE | isters | true COMO |
| еха | 12 | Alexan 9 | fruis | CHA | - Imm - Hor | CF. H. B | mlha | ire Aldinis |
| medical examiner must | | 23. PART i. Enter the diseases, or cor | nplicetions that ceused the death it only one cause on each line. | . Do not enter the π | node of dying, such as | cardiac or reapirat | ory arrest, | Approximata |
| the m | | IMMEDIATE CAUSE (Final disease or condition | Allens whom | Cheun | mies | | | interval Between Onset and Dasth |
| event, | ł | resulting in death) a., | DUE TO (OR AS A CONSEQUE | INCE OF): | | | | |
| afic e | N | Sequentially list conditions, b. | Se12515 20 | Denn | tus u | lier | | |
| traumatic | RTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | QUE TO (OR AS A CONSEQUE | INCE OF): | · of | Tulae | | |
| other t | 임 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CONSEQUE | INCE OF): | ^ | 1 | | |
| - | E | resulting in death) LAST | leeding | Bo- lulai | ed An | moret | 0. | 100 |
| 2 | CE | DARK II ON III | | | | + | | |
| 23 shows any Inju | MEDICAL | PART II. Other significant conditions | contributing to death but not result | ulting in the underlyi | ng cause given in Part | 1. 24a. WAS AN AU PERFORME | | Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 20 | | CRF An 1 | in tracernod | | | 1 🗆 YES 2 📦 | NO | OF DEATH? |
| Sho | | DID TOBACCO USE CONTRIL | | A | UNCERTAIN [| ٦ | | 1 Tes 2 No |
| T 23 | HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | OF DEATH (Check only one | | | | |
| T Item | Sic | EXAMINER? | IOSPITAL: | OTHER: | me 5 Residence 6 - | Other (Specify) | | |
| 9d, 0r | H | 27. MANNER OF DEATH | | 6b. TIME OF 26c. IP | JURY AT 28c | . DESCRIBE HOW INJU | JRY OCCURED | |
| ~ | BY | 1 Netural 5 Pending 2 Accident Investigation | (11011) | | YORK? | | | |
| 28 Is | | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY At home, building, stc. (Specify) | farm, street, factory, off | ice 28f | LOCATION (Street end City or Town, Stete) | Number or Rura | l Route Number, |
| | LET | 29a. CERTIFIER 1 DERTIFYING PHYSICIA | N: To the best of my knowledge, death | occurred at the lime de | te and place, and due to th | a causala) and ma | r an alal-d | |
| IMPORTANT: 19 | COMPL | | On the basis of examination end/or investigation | | | | | (s) end menner se stated. |
| MIA | Ö | 296. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUMBER | | | ED (Month, Day, Year) |
| IMP0 | 0 | Shelvidon & | · raigins | S | D30116 | | 8-2 | |
| | 임 | SHAHAA | OMPLETED CAUSE OF DEATH (ITEM 27 | n (Type, Print) | | | | |
| | | 31. DATE FILED (Month, Day, Year) SEP 1 1 1995 | 32. REGISTRADIS SIGNATURE Julia d'Auxilian Rans | dalle | | | | |
| | - 0 | | 1// | | | | | |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| 1 | - | | ATI | E | AR |
|---|------|-----|-----|-----|----|
| Г | t. D | ECE | DEN | T'S | NA |
| 1 | 77 | | | | |

| | REGISTRAR | | CERTIFIC | CATE OF DEA | TH | REG. NO. | | |
|-------------|-----------------------------------------------------|-------------------------------------------------------|-------------------------|---------------------------------|---------------------|-------------------------------|-----------------|----------------------------------------|
| | t. DECEDENT'S NAME (First, Middle, Last) HOWard F S | | | | MON | E OF DEATH TH DAY | YEA | 3. TIME OF DEATH |
| | | houl, Sr. | | | Ser | tember | 7 1995 | 09:47 A |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER | | E OF BIRTH hth, Day, Year) | 8. Bi | IRTHPLACE (State or Foreign ountry) |
| | 216-03-2657 | 1 2 M 2 D F 89 | YRS. | | Sen | t 8,19 | 05 M | anuland |
| er ! | 9e. FACILITY NAME (If not institution, give | | | 96. CITY, TOWN OR LOCAT | TION OF DEATH | 7 | 9c. COUNTY O | OF DEATH |
| DIRECTOR | Greater Baltimor | e Medical Cer | nter | Towson | | | Balti. | more |
| EC | 10e. STATE 10b. COUNT | TY | 10c. CITY. | TOWN OR LOCATION | | | | 10d, INSIDE CITY |
| H | Md. N | l A | | altimore | | | | LIMITS? |
| | 10a. STREET AND NUMBER | | | 101, ZIP COL | DE | | 10o CITIZEN (| t TYES 2 NO |
| FUNERAL | 2703 Chesley + | Ive. | | 2 | 1234 | | 11 C | 1 |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | | 13. WAS DECENDENT | | IN? (Specify Yes o | W No - 14. R | ACE — American Indian. |
| | 1 Never Married 2 Married | FORCES? 1 YES | | | en, Mexican, Puerto | | В | Heck, White, etc. |
| ВУ | 3 Widowed 4 Divorced | | | 1 | орволу. | | 9 | White |
| ETED | 15. DECEDENT'S EDU (Specify only highest grad | JCATION a completed) | 16a. DECEDENT'S U | de done during most of work | ring 16 | b. KIND OF BUSH | NESS/INDUSTR | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | iffe. Do NOT use | retired.) | | | | |
| COMPL | 12th | N/A | Superv | ison | THER'S NAME (First, | Can Co | ompani | <i>y</i> |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | 16. MOT | THER'S NAME (First, | Middle, Maiden Sc | Jmame) | |
| H | John T. Shoul | ! | | | ary E. | Lyon | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | C. I | 1 | DORESS (Street and Number | | | | |
| | Mrs. Elsie M. | Shoul | 1 2703 | Chesley DISPOSITION (Name of | Ave. Bo | TE 20c. LOCA | 1d. 21 | 1234 |
| | 1XC Burtel 2 ☐ Cremation 3 ☐ Ren | novel from State 20th | | | | | | |
| | 4 Donation 6 Other (Specify) | CENSEE | ulaney | Valley Ce | m = 9 | 9 Bc | ulto. | Md. |
| | | | | Hantley | M; // | Funa | / <u>H</u> . | |
| | 23. PART L Enter the diseases, or | Smith | | 7527 #9 | read & | d Rel | lax no | ne 1d_2/234 |
| | 23. PART L Enter the diseases, or | complications that caused List only one cause on e | the death. Do no | t entar tha moda of dy | ying, such aa ca | diac or reapire | itory arrest, | Approximate |
| | IMMEDIATE CAUSE (Final | | | | | | | Interval Between Onset and Dear |
| | disease or condition resulting in death) | · Congest | ive He | ct Failu | ve | | | inmedia |
| | | DUE TO (OR AS A | CONSEQUENCE OF | | , | - , 1 | | , |
| Z | Sequentially list conditions, | b. Due to (of as a Me for | temen | in + M | nid ar | rlead | | + nexthe |
| RTIFICATION | if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | 0 4 | 0 - | | | |
| 5 | cause, Entar UNDERLYING CAUSE (Disease or injury | c. Map | LYTAKZ | 1202/01 | - can | e/ | | |
| | that initiated events resulting in death) LAST | OUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| E E | | d | | | | | | |
| . 1 | PART II. Other aignificant condition | a contributing to death b | ut not rasulting in | tha underlying cause | givan in Part I. | 24a. WAS AN AL | | 246. WERE AUTOPSY FINDING |
| EDICAL | | | | | | PERFORM 1 YES 2 | | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| MEC | | | | | | | , | OF DEATH? |
| AN: | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | F DEATH YES | □ NO ☑ UNO | CERTAIN | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH | | | | | |
| S 1 | 1 YES 2 DEO | HOSPITAL: 1 Impatient 2 I ER/Outp | | OTHER: | esidence 6 🗆 Oth | er (Specify) | | |
| PHY | 27. MANNER OF-DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIME | OF 28c. INJURY AT | | SCRIBE HOW INJ | URY OCCURED |) |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (month, buy, hear) | W SO | M 1 YES 2 | NO | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, atc. (Spec | — At home, farm, etc | eet, factory, office | 281. LO | CATION (Street and | 1 Number or Rur | ral Route Number, |
| | 4 Homicide determined | and the lobbs | | | On) | or Town, State) | | |
| PLE | 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | ICIAN: To the best of my knowl | ledge, death occurred | at the time, date and place | and due to the co | use(e) and manne | or on elebad | |
| 8 | | ER: On the beele of examination | | | | | | se(e) and menner se stated. |
| 0 | 296. SIGNATURE AND PURE OF CHAPPE | // | | | | | | |
| 8 | (1UH)90 | Suy | | 296. LIC | ENSE NUMBER | 9 1 | Pd. DATE SIGN | Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF OF | ATH (ITEM 27) /June D | rint) | CSOC | | 7/ | 1/17 |
| | 4.1.1 | | | | | | | |
| | Albert Delosk | ARECSTRARY SIGN | 5 Fairm | ount Ave. | Lowson | 2, Md. | 21281 | 6 |
| | SEP-1-1 1995 A | A STUDIOR SOL | 4 | | | | | |

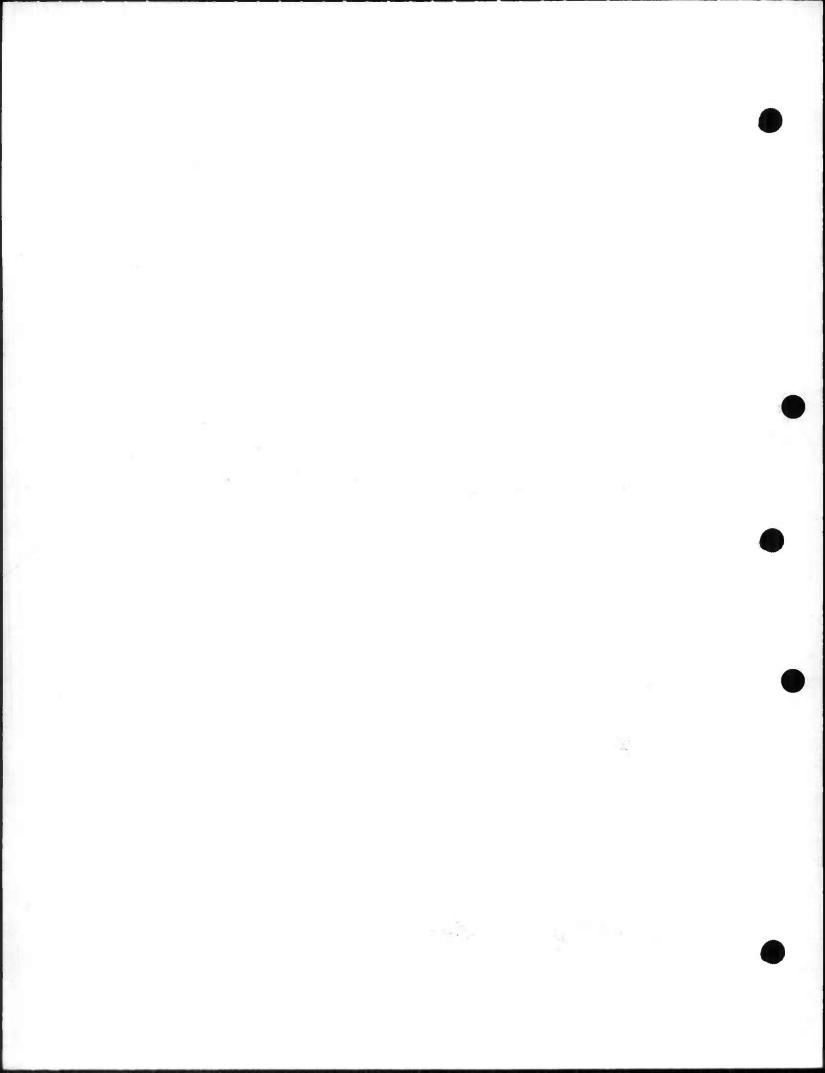
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

| | REGISTRAR | | CE | RHIFIC | ATE OF | DEATH | F | EG. NO. | | | |
|------------------|------------------------------------------------------------|------------------------------------|-------------------|---------------------|------------------|------------------------------------------|-------------------|--------------|--------------|----------|-----------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 1 | 1 | | | 2. DATE OF | | | | 3. TIME OF DEATH |
| | Tail lions | n 9 | hu | x D |) | | SP D | DAY | | YEAR | 17007 11 |
| | 4. SOCIAL SECURITY NUMBER | S. SEX 6. A | AGE (In yrs. last | birthday) IF | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF E | HTH | 1 | A. BIRTH | IPLACE (State or Foreign |
| | 213-28-4176 | M 2 D F | 64 | YRS. MO | NTHS DAYS | HOURS MIN. | (Month, De | y. Year) | 931 | Countr | (4) |
| | 9s. FACILITY NAME (If not institution, give stree | 44 | 04 | 04 | CITY TOWN | OR LOCATION OF OR | July | 10, 1 | 9c. COUN | | ryland |
| Œ | | | | | | | AIH | - 1 | 9c. COUN | TY OF D | EATH |
| 5 | Northwest Hospital | Center | | R | andall | stown | | | Bal | timo | re |
| S | 10a. STATE 10b. COUNTY | | | 10c. CITY. TO | OWN OR LOCA | TION | | | | | 10d. INSIDE CITY |
| <u>E</u> | Maryland | N/A | | | imore | | | | | ŀ | LIMITS? |
| 7 | 10e. STREET AND NUMBER | N/ II | | Dait. | | | | | | | 1 YES 2 NO |
| A | 3939 Roland Av | | | | 10 | . ZIP CODE | 1011 | - 1 | | | VHAT COUNTRY? |
| FUNERAL DIRECTOR | | | | | | ۷. | 1211 | | U.S | .A. | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 2. WAS DECEDENT EVEN FORCES? 1 1 1 | | | 13. WAS DEC | ENDENT OF HISPAN ecity Cuban, Maxica | IIC ORIOIN? (S | pecify Yes | or No- | 14. RACE | - American Indian, t, White, etc. |
| B⊀ | 3 Widowed 4 Divorced | IF YES, GIVE WAR | R DATES | | | ZXX NO Specify | | ,, 610) | | Specif | fy: |
| | | | | | 1 | | | | | | White |
| 回 | 15. DECEDENT'S EDUCAT (Specify only highest grade co | | (GA | CEDENT'S USL | done during me | ON est of working | 16b. KIN | D OF BUSH | NESS/IND | ISTRY | |
| <u>iu</u> | | College (1-4 or 5+) | life. | Do NOT use re | Nred.) | | 1 | | | | |
| ₽ | 8 | | Pho | oto Cop | у | | Cop | у Са | t | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, Middle | e, Meiden Si | urname) | | |
| BE (| Stephen Shurba | | | | | Margare | et Harr | ris | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b | . MAILING AD | ORESS (Street I | nd Number or Rural F | Route Number C | alty or Town | State Zin (| Corfe) | _ |
| 임 | Marie Canoles | | | | | enue Bal | | | | | 1211 |
| | 20s. METHOD OF DISPOSITION | | | ND DATE OF D | | | | 20c. LOC/ | | - | |
| | 1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | I from State | cemetery, crep | ne Pa | olace) Com | | | | | | laryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | LOTTAL | ne rai | | | | | | | aryland |
| | . 6.60 | 1 - + | - 1. | | A. AI | n Seitz, | Jr. I | uner | al Ho | ome | |
| | . a. allan | - Heck | SA | | 3818 | Roland Av | renue E | Balti | more. | . Ma | ryland 2121 |
| | 23. PART i. Enter the diseases, or con | nplications that car | sed the dea | eth. Do not | enter the mo | de of dving, suci | as cardiac | or respire | Mory arra | nt . | 1 Approximate |
| | snock, or neart langre. Lia | t only one cause o | n each lina. | | | 16 16 16 16 16 16 16 16 16 16 16 16 16 1 | | | atory arro | | interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | 0 000 | . \- | - | | 1 -1 | 10 | | | | Onset and Death |
| | resulting in death) a | HOU | AS A CONSEO | KI | ICEA | nato | DOLL | MI | | | |
| | | DUE TO (OR) | AS A CONSEO | UENCE OF): | V | 0 | 1 - | - | | | |
| S | Sequentially list conditions, b. | 211 | ano | RI O | | 17-66 | 131 | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR | AS A CONSEU | WENCE OF): | | | U | | | | |
| 5 | CAUSE (Disease or injury | | | | | | | | | | |
| 声내 | that initiated eventa resulting in death) LAST | DUE TO (OR / | AS A CONSEQ | UENCE OF): | | | | | | | |
| 1 | d. | | | | | | | | | | |
| - 11 | PART II. Other aignificant conditions of | contributing to deal | h hut not re | aultina in ti | n amatanlala | anno Atom to | D-01 | Hara di . | | | |
| EDICAL | 00.10 | On Charles | A A | auting in tr | a underlyin | cause given in | Part I. 24a | PERFORM | | 24b. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| ă | referre Laty | O HOSTY | 00 | DIA U | 14 (| DYON | 10 | YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | Kenay Lay | 20190 | | | ,) | | | | | | 1 TES 2 NO |
| ż | DID TOBACCO USE CONTRIB | BUTE TO CAUSE | OF DEAT | TH YES |] NO [| UNCERTAIN | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | E OF DEATH (C | | 3= | 7-1 | | | | |
| S | | OSPITAL: | Outpatient 3 (| | HER: | e 5 🗆 Rasidence | • [] (Mb /C) | n a Mari | | | |
| È∥ | 27. MANNER OF DEATH | 28a. DATE OF INJU | RY | 28b. TIME OF | | | 28d. DESCRIB | | HIEV OCCI | (DED | |
| | Natural 5 Pending | (Month, Day, Ye | er) | INJURY | WO | RK? | Zou. DEGOME | L HOW HAD | ONI OCCE | MED | |
| BY | 2 Accident free atlgation | 28s. PLACE OF INJ | IIDV At hom | no form store | | | | 4.40 | | | |
| | 3 Suicide 8 Could not be determined | building, etc. (| Specify) | ire, rerrit, street | , tactory, offic | | 28f. LOCATION | | d Number o | r Rumi A | oute Number, |
| ᇤ | | | | | | | | | | | |
| ᆲᆙ | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL | N: To the best of my k | nowledge, des | th occurred at | the fime, date | and place, and due | to the cause(s) | and manne | er as stated | d. | |
| COMPLET | one) 2 MEDICAL EXAMINER: (| | | | | | | | | | and manner as stated. |
| | 296, SIGNATURE AND TITLE OF CERTIFIER | | 1 | | | 29c. LICENSE NUM | | - | | | 10 CO 100 CO |
| 8 | 1010017 A | X n | () | ~ ` | | D & C | ~ · · | , [| NO. DATE | PHUNED | (Month, Day, Year) |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF | DEATH STEE | (4) |) | 1/23 | 1126 | | - 90 | 11) | 747 |
| | HART 7 | CAUSE OF | 191 | | 7 | 000 | O cre | DG | 19 0 | WL | D 21/17 |
| | PPHY | 4- 04 | (1) | Wal |) 0 | () () | (11.98 | NO | an | MI |)x - |
| | SFP 1 1 1995 | REGISTRAR | GNATURE | | | | | | | - | |
| 10 | OF IT 1999 | | | | | | | | | | |

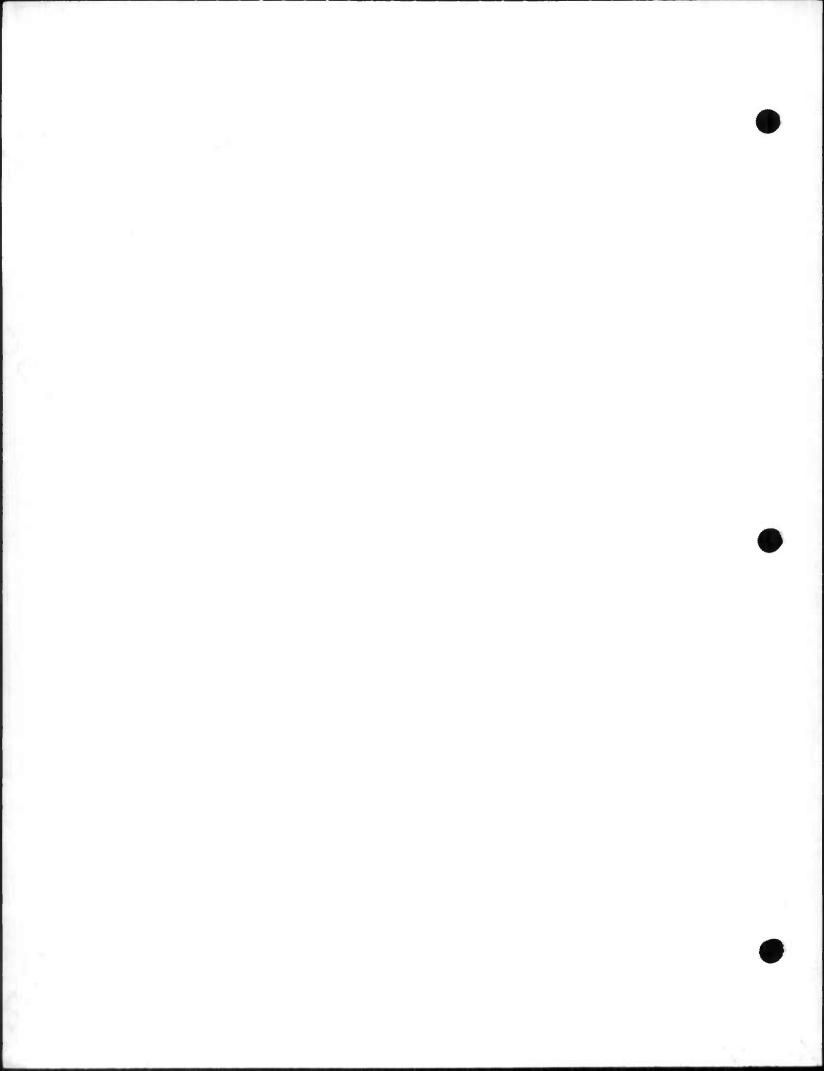


DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| R | | STATE OF | MADVI AND | / DEDARTMEN | IT OF U | CALTIL AN | ID I |
|---------|-------|----------|-----------|-------------|---------|-----------|------|
| menaed: | 1.tem | #30, | 9/11/ | 95, CYW, | per | f.h. | |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO. |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) Morris Lester Taylor Jr. 2. DATE OF DEATH SEPTEMBER 8, 1995 3:14 AM VEAR 3:14 AM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 20-20-40-54 1 MM 2 F 6. AGE (In yrs. last birthday) 98. FACILITY NAME (if not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATN 90. CITY, TOWN OR LOCATION OF DEATN 90. COUNTY OF DEATN 90. COUNTY OF DEATN |
| TOR | Sinai Hospital Residence of Decedent 96. CITY, TOWN OR LOCATION OF DEATH 8c. COUNTY OF DEATH NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH NAME (If not institution, give street and number) |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? |
| FUNERAL | 3722 Manchester Ave 101. ZIP CDOE 109. CITIZEN OF WHAT COUNTRY? 21215 |
| BY FUI | 11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS OECEDENT SVER IN U.S. ARMED FORCES? 1 D. VES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-Black, White, etc.) 16. RACE — American Indian, Black, White, etc. 16. Specify: Black, White, etc. |
| LETED | 15. DECEDENT'S EOUCATION (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY |
| E COMPLET | 12th NA Crain Operator Balto Gas + Elec Co. 17. FATHER'S NAME, (First, Middle, Leat) MOrris Taylor Sr. 18. MOTHER'S NAME (First, Middle, Melden Surname) Mable Nophlin |
| TO B | 190. INFORMANT'S NAME (TyperPrint) Laura C. Taylor 3722 Manches ter Ave Balto, and 21215 |
| | 200.METHOD OF OISPOSITION 1 Deutel 2 Cremeton 3 Removel from State 200.PLACE AND DATE OF OISPOSITION (Name of Complete) DATE 200. LOCATION - City or Town, State 200. PLACE AND DATE OF OISPOSITION (Name of Complete) DATE 200. LOCATION - City or Town, State 200. LOCATION - City or Town, State 200. PLACE AND DATE OWING DATE OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWING OWIN |
| | 22. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March F. H-West H300 Wabash Aue |
| | 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) s. Grate my caudal affects s. Our month and Death |
| ATION | Sequentially list conditions, If any, landing to immediata cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): |
| ERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST |
| G | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS |
| OICA | |
| ME | COPD - Sever T pulmonay hypertains Performed? 1 yes 2 kno AMALABLE PRIOR TO COMPLETION OF CAUSE OF EATH? 1 yes 2 kno 1 yes 2 kno |
| IN: MEDI | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN |
| ICIAN: ME | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? HOSPITAL: OTHER: |
| HYSICIAN: MET | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMMER? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 3 NO 1 YES 4 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 5 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 7 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 6 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 NO 1 YES 7 N |
| BY PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28a. DATE OF INJURY MORK? 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED |
| BY PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Inpetient 2 Ref/outpatient 3 DOA OTHER: 1 Inpetient 2 Ref/outpatient 3 DOA OTHER: 1 Nortural 5 Pending Investigation 28a. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office 28e. PLACE OF INJURY — At home, farm, street, factory, office |
| BY PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| BE COMPLETED BY PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMMER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Inpetient 2 MEDICAL EXAMMER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE OF INJURY AT WORK? 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) |
| E COMPLETED BY PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Inputent 2 Ren/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 28b. DIME OF INJURY AT WORK AND NURSE OF INJURY AND INJURY OCCURED Nome of Injury At Nomicide 8 Could not be determined 28b. Could not be determined 28b. Could not be determined 28c. (Specify) 29b. CERTIFIER (Check only one) 20c. PLACE OF DEATH (Theck only one) 28c. INJURY AT WORK AND NUMBER Of INJURY OCCURED 28c. INJURY AT WORK AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print) 29c. CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29c. DEATH OF THE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) |
| BE COMPLETED BY PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMMER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Inpetient 2 MEDICAL EXAMMER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE OF INJURY AT WORK? 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) |



727, item #1, 9/11/95,cyw, per f.h.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------|---------------------|------------------|--------------------------|----------------|----------------------------------------|----------|
| | GEORGE THOM | AS TE | EMPLE | JR. | | | AUGUST | | 95 11:05 P | DM |
| | 4. SOCIAL SECURITY NUMBER 5. S | SEX 6. AGE (| n yrs. last birthday) | IF UNDER 1 Y | EAR IF L | INDER 24 HRS. | 7. DATE OF BIRTH | Per 6 | . BIRTHPLACE (State or Foreign | |
| | 212-16-4488 1 | M2 DF | // YRS. | MONTHS DA | AYS HOL | JPIS MIN. | (Month, Day, Year) | 84 | mary make | |
| | 9a. FACILITY NAME (If not institution, give street a | and number) | | 96. CITY, TO | WAN OB YO | RE CI | | | Y OF DEATH | |
| 5 | BON SECOURS HOS | PITAL ER | | BALL | TMO. | RE CI | I I | | 1/14 | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | 1 | Land marine every | |
| 빌 | 100. STATE 10b. COUNTY | 114 | 10c. CIT | Y, TOWN OR L | OCATION | | | | 10d. INSIDE CITY LIMITS? | Ų |
| | 10a, STREET AND NUMBER | /// | 1 | 14/1 | 101. ZIP | CODE | | I son CITIZE | t TES 2 NO | \dashv |
| RA | 1111 E, 20 Th | Theo | 1 | | 101. 21 | 2/1 | 0 | 1 | LSA | - 1 |
| FUNERAL | | WAS DECEDENT EVER IN | U.S. ARMED | 13, WAS | DECENDE | ENT DE NISPAN | IIC ORIGIN? (Specify Y | e or No — t | 4. RACE — American Indian, | - |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | | YES 2 | | n, Puarto Rican, etc.) | | Black, White, etc. | - 1 |
| ВУ | 3 Widowed 4 Divorced | | | | 4 | | | | BIACK | |
| TED | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp | | 18a. DECEDENT'S | work done duri | | working | 16b. KIND OF B | JSINESS/INDU | ŜTRY | - 1 |
| ۳ | Elementary/Secondary (0-12) Co | ollege (1-4 or 5+) | life. Do NOT u | t and p | + | | | | | - 1 |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | 0 | 0// | 136/ | 18 | MOTHER'S NA | ME (First, Middle, Maide | n Surnamal | | - |
| | Coe made than | ne Tem | 1/0) | -0 | 10. | Anne | He. | 6 . | son | - 1 |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 13 1011 | 19b, MAILING | ADDRESS (S | treet and Ni | umber or Rural I | Route Number, City or To | | | |
| 2 | Mrs. BARber. | Johnson | 1111 | F 20 | m5 | treet | BAITIN | me 5 | nd 2/218 | = |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramoval | 20b | PLACE AND DATE | | ON (Nama of | | BATE 20c. L | OCATION - CI | ty or Town, State | |
| | 4 Donation 8 Other (Specify) | | Pery, cremetory or o | nouni | T CI | emator | 1/11/1 | DAITI | more Ind. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | EE . | , | 22, NA | ME AND AL | PRESS OF FA | 1155 F4 | Nern. | 1 Home | |
| | Xoseeli L. I | Puss; | | 22 | 23 | W. No | Vth Ave | BAI | timore my 21 | 12/ |
| | 23. PART I. Enter the diseases, or companion, or heart failure. List | | | not enter th | a mode o | of dyling, suc | h as cardiac or rea | piratory arre | st, Approximate interval Between | |
| | IMMEDIATE CAUSE (Final | orny one cease on a | ecii iiire. | • | | | | | Onset and Dea | |
| | disease or condition resulting in death) | | DUMAL | | | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE | PF): | | | | | | |
| ON | Sequentially list conditions, b | DUE TO (OR AS | CONSEQUENCE C | IEI- | | - | | | | - |
| AT | if any, leading to immediate cause. Enter UNDERLYING | 502 10 (011 20) | , consedernor c | ,, j. | | | | | ĺ | |
| FIC | CAUSE (Disease or injury c. — that initiated events | DUE TO (OR AS | CONSEQUENCE | PF): | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | PART II. Other significant conditions co | ontributing to death b | out not resulting | In the unde | rivina ca | use given in | Part i. 24s. WAS A | N AUTOPSY | 24b. WERE AUTOPSY FINDING | 38 |
| EDICAL | TAIL III OTHER SIGNATURE OF | on the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th | at not resenting | III allo olloc | niying ou | use giveir iii | PERF | PRMED? | AMAILABLE PRIOR TO COMPLETION DF CAUSE | |
| ED | | | | | | | TUR | | OF DEATH? | |
| Σ | DID TOBACCO USE CONTRIB | UTE TO CAUSE C | F DEATH Y | ES 🗍 NO |) P (| JNCERTAI | | 100 | THE TES 2 LINO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF OE | | | | | | | |
| SIC | | OSPITAL: ☐ Inpatient 2 ☐ ER/Out | ontlant 3 EXTOOA | OTHER: | g Home 5 | ☐ Residence | a Other (Specify) | | | |
| Ήγ | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TH | ME OF 28 | Bc. INJURY WORK? | AT / | 28d. DESCRIBE NOV | | A. L. | 25 |
| ВУ В | 1 Natural 5 Pending | | 5 221 | | | 2 NO | Subjecti | D KID CE | d Shake from | |
| | 3 Suicide a Could not be | 28a, PLACE OF INJURY building, atc. (Spe | orfy)(| atreet, factory | , offica | | City or Town, Sta | (a) | or Rural Route Number, | , , |
| ETE | 4 Nomicide determined | | HOME | | | | 3112 BM | Ken-Si | - BALTIMEREM | 9 |
| COMPLETED | CONSTRUCTION OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE C | : To the best of my know | | | | | | | | |
| ON | one) 2 MEDICAL EXAMINER: O | n the basie of examination | n and/or Investigat | lon, in my opir | nion, death | occured at the | time, date and place, | end due to the | cause(s) and manner as stated. | |
| BE (| 29b, SHINATURE AND TITLE OF CENTURES | 1/ 00 | | | 290 | LICENSE NUI | | | SIGNED (Month, Day, Year) | |
| TO E | moune love | youl | | | | 0.C.1 | M.E | AUG | UST 29,1995 | |
| | 30. NAME AND ADDITIONS OF PERSON WHO CO | OMPLETED CAUSE OF OR | | | Str | eet | Raltimor | e Ma | ryland 2120 |) 1 |
| | 31. DATE FILEDOMONIA CON Venti 40 0 5 | 32 PEGISTRAR'S SACH | | r eiiii | SLL | CCL, | DOT CTINOT | C, FIG | Lyluna 2120 | 1 |
| | 31. DATE FILED SEPTEM 1 1995 | 32/ RECISTRATS SIGN | ertandall | | | | | | | |

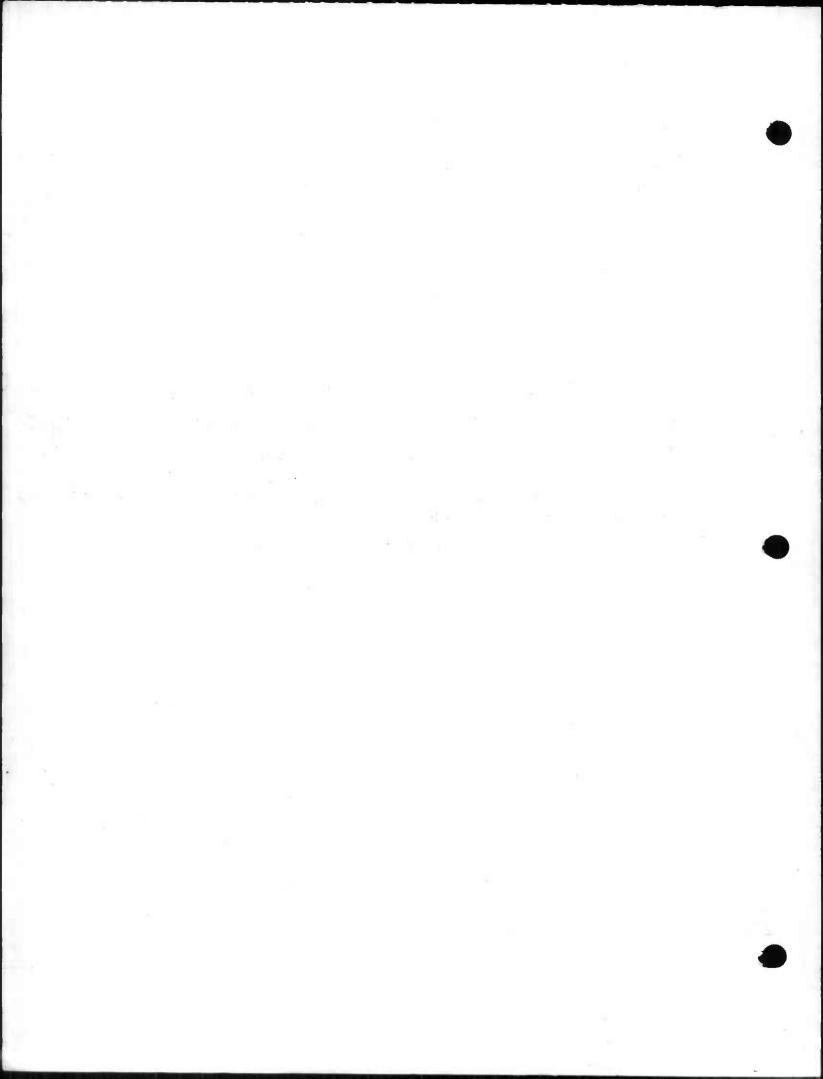
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, 2.4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

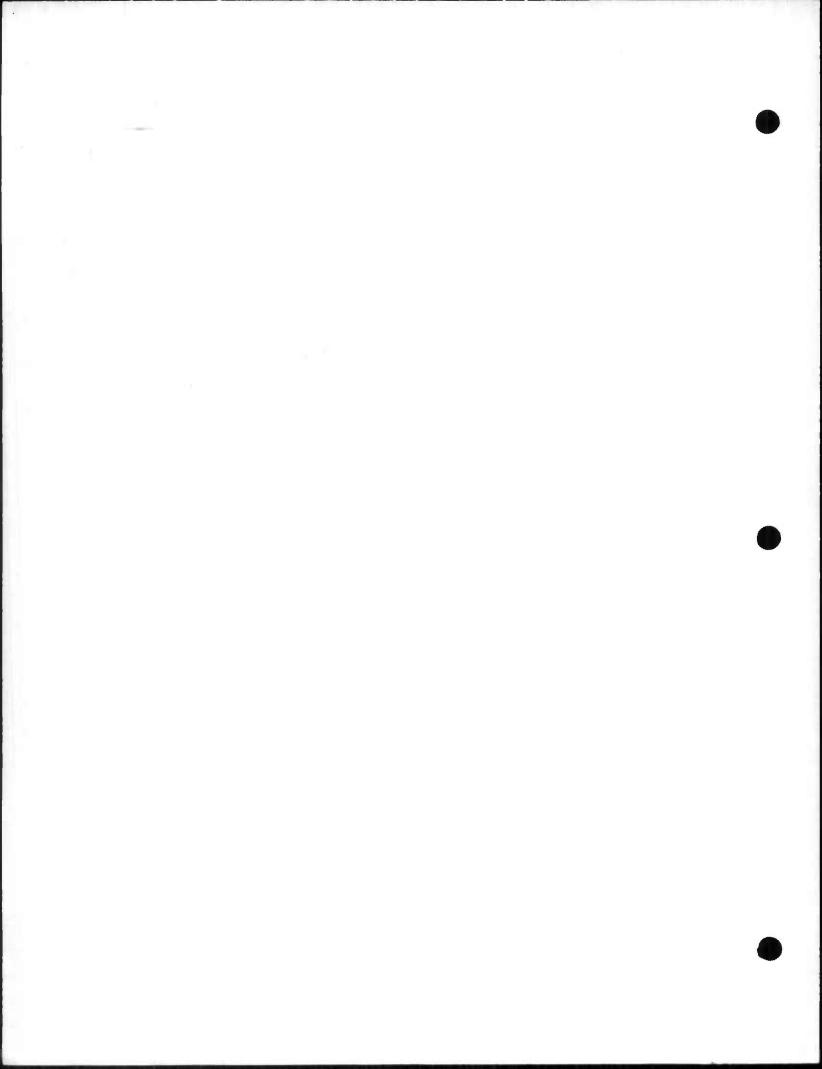
BALTIMORE, MARYLAND 21215-0020



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without after fround after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funer-transit permit. Pages 1. | s after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| SPITAL OR ATTENDING PHYSI | ERAL DIRECTOR: After this c | in 72 hours after death with | T: If item 28 is marked. |
| TO THE HOS | TO THE FUN | be filed with | IMPORTAN |

| | | | D / DEDARTME | NT OF HEALTH AN | MENTAL HYGI | ENE | | |
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| | 1 - STATE REGISTRAR | STATE OF MARYLAN | | TE OF DEATH | REG. | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | OLITITIOA | TE OF BEATT | 2. DATE OF DEAT | 7.10 | 5 3.1 | TIME OF DEATH |
| H | EMMA E W: | LIAMS | | | 3 CO | 8 19C | YEAR 2 | 00:581 |
| | 4. SOCIAL SECURITY NUMBER | 4.0 | | DER 1 YEAR IF UNDER 24 HR | Character Constant | | BIRTHPLA | CE (State or Foreig |
| | 214405470 | 1 DM 2/25 79 | YRS. MONTH | S DAYS HOURS MIN | Jun 14 | 1916 | Country) | MD |
| _ | 9a. FACILITY NAME (If not institution, give | street and number) | 9b./9 | ITY, TOWN OR LOCATION OF | | | Y OF DEATH | 4 |
| စုံ | HOWARD County | GENERAL HOS | p.tal C | 1 lumbia | | Ho | NaRO | |
| DIRECTOR | 10a. STATE 10b. COUN | Y | 10c. CITY, TOW | N OR LOCATION | | | 104 | . INSIDE CITY |
| 듬 | MB Ho | 19AWC | | em BLA | | | 100 | LIMITS? |
| A. | 10e. STREET AND NUMBER | 0 1 | | 101. ZIP CODE | | 10g. CITIZE | | COUNTRY? |
| E | 10128 LV21 | URE GATE | -ANE | 21044 | ŧ. | U: | SA | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 | S ARMED | 13. WAS DECENDENT OF HIS | PANIC ORIGIN? (Specify | Yea or No- 1 | 4. RACE — A Black, Wh | American Indian, |
| ВУ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATES | , Mas | If yes, specify Cuban, Ma: 1 TES 2 NO Sp | | ' | Specify: Q | i . I |
| ED | 15. DECEDENT'S EDU | ICATION | | | | | - + | YACK |
| ETE | (Specify only highest grad | e completed) | OECEDENT'S USUAL (Give kind of work do life. Do NOT use retired | ne during most of working | 166. KIND OF | BUSINESS/INDU: | STRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | Suidan | C 1 | ne 1 = 1 | -Cita | Scho | 25/0 |
| COMP | 17. FATHER'S NAME (First, Middle, Lest) | 3 | 34.44.14 | | NAME (First, Middle, Mai | den Surname) | -100 | |
| BEC | Enoch G. M | IQSON DR. | | FILE | NEL | 2000 |) | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b, MAILING ADDRI | ESS (Street and Number or Ru | al Route Number, City or | Town, State, Zip C | ode) | 1 |
| - | Deborah H | TARRISON | 20 W | inesap(| ourt Co | visuotx | 12/1 | 1 2122 |
| | 20e, METHOD OF DISPOSITION 1 D Burtel 2 Cremetion 3 Ren | 20b. PL/ | ACE AND DATE OF DISP y, cremetory or other place | POSITION (Name of | DATE 20c | LOCATION - CI | y or Town, S | Stata |
| | 4 Donation 5 Other (Specify) | | sutus He | map: al Kith | 91295 1 | Salto. | M | |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LI | | | MICE INT. | 14-1- | | | |
| | . 0 1 | CENSEE | | 22. NAME AND ADDRESS OF | 14-1- | e- Wes | + | |
| | - Glemi | censee D. Lost | | 22. NAME AND ADDRESS OF ARECK FUND | FACILITY 1 | Ba Ho | + Mc | 1 2121 |
| _ | 23. PART)I. Enter the diseases, or shock or heart falling | Complications/that caused the | e deeth. Do not en | JARCH FUNG | MOLLOY HOR | Batte | + 4c | |
| | IMMEDIATE CAUSE (Final | B. Scot | e deeth. Do not en | JARCH FUNG | MOLLOY HOR | Batte | + Mc | Interval Betw |
| | anock, or meer failure. | complications/that caused the | e deeth. Do not en | JARCH FUNG | MOLLOY HOR | Batte | + Mc | Interval Betw Onset and D |
| | IMMEDIATE CAUSE (Final disease or condition | complications/that caused the | e deeth. Do not entilline. | JARCH FUND 4300 Wah der the mode of dying, a | FACILITY HOR | Ba Ho | + Ma | Interval Betw Onset and D |
| NO | IMMEDIATE CAUSE (Final disease or condition | complications/that caused the List only one cause on each a. Cor Plw DUE TO (OR AS A CO) | e deeth. Do not entilline. NONCILE NSEQUENCE OF: Obstructi | JARCH FUNG | FACILITY HOR | Batte | to Ma | Onset and D |
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YES 2 NO |



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| | it permit. | |
| physician. | Irans | |
| ospital or attending | use as the burial- | |
| he hospital o | detached for us | |
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| may be retained | c, pag | |
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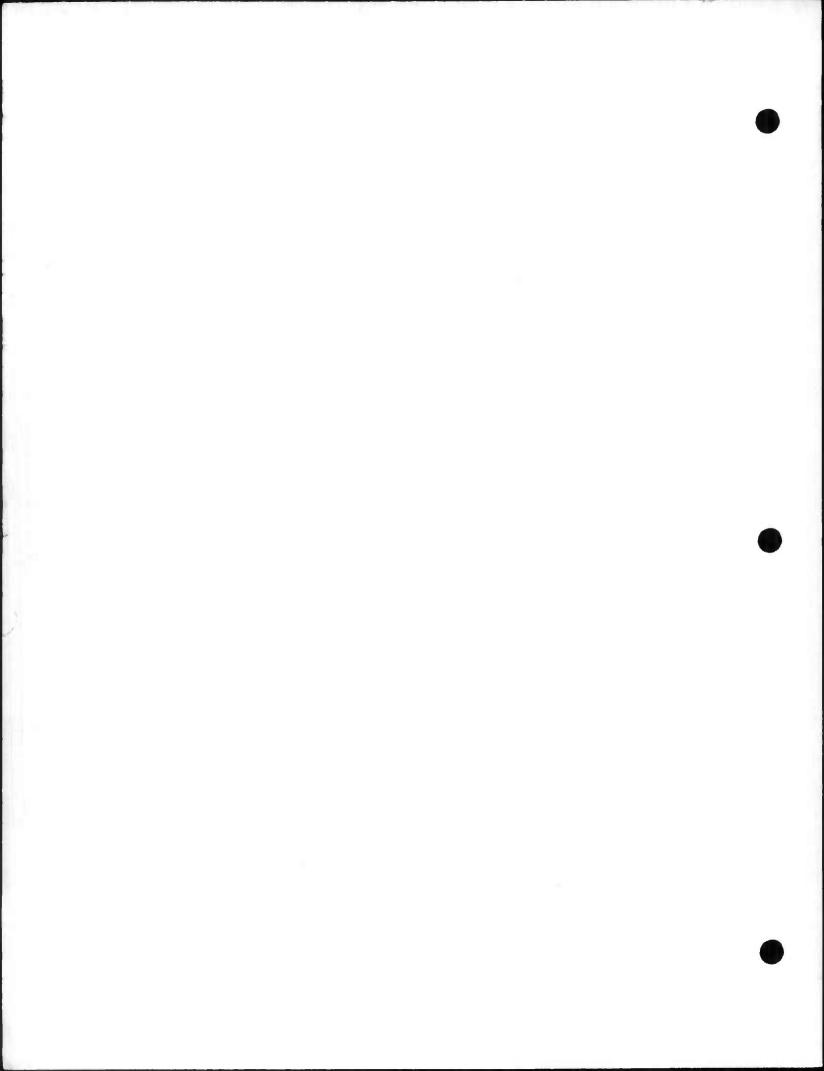
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | 2. DATE OF DEAT | | MEAR | 3. TIME OF DEATH |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------|------------|-----------|----------------------------------------------------------------------|------------------------------------------------------------------|---------------|--------------------------|------------------------|---------------------------------------------------------------------|---------------------------------|-------------|-----------------------------------------------|
| | | Erika Wilbert | | | | | | | | | SEPT 8 TH 1995 17:20 1 | | | 17:20 PM | |
| | | 4. SOCIAL SECURITY NUMBER | | 5. SEX 6. AGE (In yrs. lest b | | | | | | | 7 DATE OF BIRTH | | B BIFTHPI ACE (State or Foreign | | |
| 9 | | 231-34-370 | 2 | 1 🗌 M 2 💢 F | 8 | 37 | YRS. | MONTHS | DAYS | HOURS | MIN, | Feb 25, | [908 | Gen | cmany |
| 3 should | _ | Ba. FACILITY NAME (If not in | | | | - | | 9b. CITY, | TOWN | OR LOCATIO | ON OF OE | ATH | 9c. CO | UNTY OF E | |
| cvi | E | Union Memorial Hospital | | | | 1 | | | Ba. | ltim | ore | City | | N/A | A |
| Jes 1. | DIRECTOR | 10a. STATE | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE CITY | | |
| æ. | 盲 | Maryland | | N/A | | | B altimore | | | | | | LIMITS? 1 F YES 2 NO | | |
| perm | FUNERAL | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| an. ransit | 買 | 3838 Roland Avenue | | | | | 2121 | | | | | | | | |
| physician bunal-tra | | 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 ☐ YES 2 ☒️ | | | | 2 X NO | O If yes, specify Cuban, Maxican, Pu | | | | n, Puarto Rican, etc | IGIN? (Specify Yea or No 14. RACE American Indi rto Rican, etc.) | | | |
| ending physician. as the bunal-transit permit. Pages 1, | B | 3 Widowed 4 Divo | | IF YES, GIVE WAR OR DATES | | | 1 YES 2 NO Specify: | | | r | Sp | | White | | |
| the hospital or attending detached for use as the once. | 요 | 15. OEC | EDENT'S EDU | CATION completed) | 1 | | EDENT'S USUAL OCCUPATION re kind of work done during most of working | | | | 16b. KIND O | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| the hospital or atti detached for use once. | 9 | Elementary/Secondary (0 | | College (1-4 or 5 | +) | life. Do | o NOT use | retired.) | uning inc | out or working | y | | | | |
| he hospi detached once. | BE COMPLETE | unknown | | | | Ноп | nemak | ker | | | | Own I | | | |
| be det | | 17. FATHER'S NAME (First, MI | | ph Deuts | ch | | | | | | | ME (First, Middle, Mi L. Meyer | iden Surname) | | |
| should I | | 19a. INFORMANT'S NAME (7) | | .pn bedee | | 19b. 8 | MAILING A | ADDRESS | (Street) | | | Route Number, City o | Fram Chain 7 | la Cadal | |
| e retained 5 Should notified | 임 | Ann Smith | | | | | | | | | | more, Ma | | | 211 |
| leath. Page 6 may be funeral director, page xaminer must be | | 20a. METHOD OF DISPOSITI | ISPOSITION 20b. PLACE AND DATE OF DISPOSITION (A | | | | TION /N/ | ame of | | DATE 20 | LOCATION - | - City or Tr | wn State | | |
| ge 6 ma lirector, p | ! | VX Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place) St. Mary S Cemetery (Hampden) 9/11/95 Baltimore, Marylnad St. Mary S Cemetery (Hampden) St. Mary S Cemetery (Hampden) St. Mary S Cemetery (Hampden) St. Mary S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (Hampden) S Cemetery (| | | | | | | | | | | | | |
| death. Pag tuneral dir I. examiner | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | 22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home | | | | | | | |
| ter dea the fur al exa | | 3818 Roland Avenue Baltimore, Marylnad 2121 | | | | | | | | | | | | | |
| hours after death. Page 6 may be retained by ed in by the funeral director, page 5 should be or removal. medical examiner must be notified at | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | | |
| filled tion, or the m | | IMMEDIATE CAUSE (Final | | | | | | | | | | | | | |
| completely ial, cremati, event, tl | | disease or condition resulting in death) e. MYU CARD I AL RUPTURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ind comp burial, ci | _ | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions b. Acut & MI 20 MINS | | | | | | | | | | | | | |
| 8 " 9 E | 5 | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF | | | | | | F): | | | | | | | |
| physician ne prior to | CA | cause. Enter UNDERLYI CAUSE (Disease or Inju | NG | a Copo | NAR | Ч | | TER | 4 | DISS | ASE | | | | 5 YRs. |
| ing phy ygiene p other | 빝 | that initiated events resulting in death) LAS | | OUE TO | (OR AS A C | CONSEQUE | ENCE OF): | : | | | | | | | |
| requires that the death certificate be een signed by the attending physician of Health and Mental Hygiene prior shows any injury, or other trau | CERTIFICATION | d | | | | | | | | | | | | | |
| by the att and Menta iy injury, | AL | PART II. Other algnifice | nt condition | s contributing to | deeth but | t not res | uiting in | the un | derlyln | g ceuse g | lven in | Part I. 24a. WA | B AN AUTOPSY | 7 24b | . WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| signed by Health an Nws any | AEDICAL | HYPERTE | NSION | | | | | | | | | 1 | 1 - YES 2 - 10 | | COMPLETION OF CAUSE OF DEATH? |
| w requires been sign of, of Heal | - 1 | 212 2221 221 | | | | | | | | | | | | 1 TYES 2 NO | |
| has be Dept. | AN | DID TOBACCO | | CONTRIBUTE | то с | CAUSE | OF | DEAT | | | | | | | |
| SICIAN: The law certificate has th the State Dept d, or item 23 | SICIAN: | EXAMINER? | J WEDICHE | HOSPITAL: | EB/Outpet | Name 2 🗆 | DOA | OTHER | 4 | | | ock only one) | | | |
| Certific the the d, or | PHY | 27. MANNER OF OEATH | | 28s. DATE OF | INJURY | - Y | 28b. TIME | OF | 28c. INJ | JURY AT | aldenca | 6 Other (Specify, 2ad. DE\$CRIBE H | OW INJURY O | CCURED | |
| NG PHYS fter this cath with marked, | ВУР | | Pending Investigation | (Month, L | Jay, Year) | | INJU | M | | YES 2 | NO | | | | |
| R: After er death | 28. DCAZTION (Street and Number or Rubling State) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (Street and Number or Rubling) 28. LOCATION (St | | | | | | | | er or Rural i | Route Number, | | | | | |
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law THE FUNERAL DIRECTOR: After this certificate has b filed within 72 hours after death with the State Dept. PORTANT: If Item 28 is marked, or Item 23 | ETE | 4 Homicide determined | | | | | | | | | | | | | |
| AL OR A AL DIREC 72 hours If Item | APL | 29a. CERTIFIER (Check only one) One) CERTIFYING PHYSICIAN: To the beat of my knowledge, daeth occurred at the time, data and place, and due to the cause(a) and manner se steted. | | | | | | | | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL I DE filed within 72 h IMPORTANT: If I | 29a. CERTIFFIER Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner se state one) 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the | | | | | | | | the cause(| i) and manner as stated. | | | | | |
| THE Filled w | BE | 29b. SIGNATURE AND TITLE | OF CERTIFIE | LAND | | | | | | | NSE NUM | DZA F | 29d. DA | | (Month, Day, Year) |
| 2 6 3 X | 5 | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CALL | SE OF DEAT | н лтем э | 27) /5ma 1 | Derine's | | 11/2 | 438 | 746 | | 9/8/ | 95 |
| | | ARVINDER | | | | | | | L fto | SPITA | u, - | BALTIMO | LE MA | RYLA | ~D |
| 6 | | 31. DATE FILED (Month, Day, SEP 1 1 199) | | 22. REGISTRA | | | | | | | | | - / | | |
| | | SEP 1 1 199: | 0 9.1 | in Mudles | Market | Ц | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | De Tilled within 12 hours after death with the State Dept, or reading and mental Hygiene phor to bunda, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL OR ATTEND | TO THE FUNERAL DIRECTOR: A | De nied within 72 hours after d | IMPORTANT: If Item 28 is | |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTI | | | MENTAL HYGIEN | | | | |
|-----------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------|-------------------------------------|---------------------------------------------------------|--------------------|-------------------------------------------------|-----------------------------------|------------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | | THEODORE | F F | ANDREW | S | July 31 | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF BIRTH | a pur | THPLACE (State or Foreign | | |
| | 220-12-1738 | 1XXXM 2 □ F 79 | YRS. | ONTHE DAYS | HOURS MIN. | 06/06/1 | Month, Der Wer) 06/06/16 Maryland | | | |
| _ | 9e. FACILITY NAME (If not institution, give etr. | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | |
| DIRECTOR | Memorial Hospi | tal of East | on | East | on | | Tal | bot | | |
| 딦 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c CITY T | OWN OR LOCAT | ION | | | | | |
| E | Maryland Card | line | 100.011,1 | OTTO OT LOCAL | | nton | 10d. INSIDE CITY LIMITS? | | | |
| | 10a. STREET AND NUMBER | | | 101 | ZIP CODE | 10011 | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| ER/ | Market St | | | 2162 | 29 | | d States | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. | | 13. WAS DEC | | NIC ORIGIN? (Specify Yes | | CE - American Indian, | | |
| | 1 Never Married 2 1 Married | FORCES? 1 YES 2 I | XNO | If yes, spe | 2 X NO Specifi | in, Puerto Rican, atc.) | Bia | ck, White, etc. | | |
| ВУ | 3 Widowed 4 Divorced | | | | - Zg 110 opton | , | Spir | White | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | completed) | DECEDENT'S US (Give kind of work | done during mos | N st of working | 16b. KIND OF BUS | SINESS/INDUSTRY | | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Farme | etired.) | | Acri | cultur | | | |
| M | Fifth 17. FATHER'S NAME (First, Middle, Last) | | raime | T | | | | e | | |
| 8 | | narles E. An | drowe | | | ME (First, Middle, Maiden A. Reev | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | 000000000000000000000000000000000000000 | | Route Number, City or Tow | | | | |
| 2 | Bonnie Littlet | on | | | | Ellendale | | 9941 | | |
| | 20s. METHOD OF DISPOSITION 1 | | EANDOATEOF | | | | CATION — City or | | | |
| | 1 Buriel 2 S-Cremation 3 Ramon 4 Donation 5 Other (Specify) | | cremetory or other bridge | placa) | | | mbridg | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | Dilage | | D ADDRESS OF FA | | | - | | |
| | Muline 7. | Galoma | | | | | | neral Home | | |
| | 23. PART I. Enter the diseases, or co | mnlications that caused the | don'th Do not | PO B | x 43, F | ederalsb | urg, M | | | |
| | shock, or heart fallure. L | lat only one cause on each li | ne. | auter file lilot | e or dying, suc | n as cardiac or respi | ratory arrest, | Approximata Interval Between | | |
| | iMMEDIATE CAUSE (Final disease or condition | A | 3. | T | | | | Onset and Death | | |
| reaulting in daeth) a. Male OM es. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 20 12.14 | | |
| z | corner ater dissess | | | | | | | | | |
| 임 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSTOUENCE OF): | | | | | | 1 | | |
| 2 | CAUSE (Disease or Injury | MSCVI | , | U | | | | V | | |
| E | that initiated events resulting in death) LAST | DUE TO (OR AS A CONS | SEOUENCE OF): | | | | | | | |
| CERTIFICATION | d. | | | | | | | | | |
| AL. | PART II. Other algnificant conditions | contributing to death but no | t resulting in t | he underlying | cause given in | Part I. 24s. WAS AN | | b. WERE AUTOPSY FINDINGS | | |
| Š | Mosepais | Dreuninia | D | x abeti | Ze- | PERFOR | | AMILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MEDIC | | he col | thes_ | | | | 7 | OF DEATH? | | |
| ž | DID TOBACCO USE CONTR | BUTE TO CAUSE OF DE | ATH YES | NO 🗆 | UNCERTAIN | v 🗆 | | 1 0 100 1 0 110 | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PL | ACE OF DEATH (| | | | | | | |
| IS. | A CI MED A POLICE | 1 Inpetient 2 ER/Outpetient | | THER: Nursing Home | 5 Residence | 6 Other (Specify) | | | | |
| H | 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME O | | | 28d. DESCRIBE HOW II | NJURY OCCURED | | | |
| à l | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 Y | ES 2 NO | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At building, stc. (Specify) | home, farm, stree | et, factory, office | | 26f. LOCATION (Street e City or Town, State) | nd Number or Rural | Route Number, | | |
| Ē, | | | | | | | · | | | |
| COMPLETED | | AN: To the best of my knowledge. | | | | | | | | |
| Ö, | 2 MEDICAL EXAMINER: | On the basis of examination end/o | or Investigation in | n my opinion, de | eth occured at the | time, date and place, an | d due to the cause | (e) end manner as stated. | | |
| 8 | 29K SIGNATURE AND TITLE OF CENTIMER | 6/1/ | 11/ | 1 | 29c MICENSE NUN | IBER | 29d. DATE SIGNE | D (Month, Day, Year) | | |
| 2 | I WEW I I | entities. | | 1 | 207 | off | 13 | 1147 | | |
| | 30. NAME AND ADDRESS OF PERSON WHO Albert T. Dawk | | | | Ave. | Easton, | MD 216 | 501 | | |
| | 31. DATE FILED (Month, Day, Year) | 32/REGISTRAR'S SIGNATURE | | | | | | | | |
| | AUG - 1 '95 | Gula Davidson-A | andell | | | | | | | |



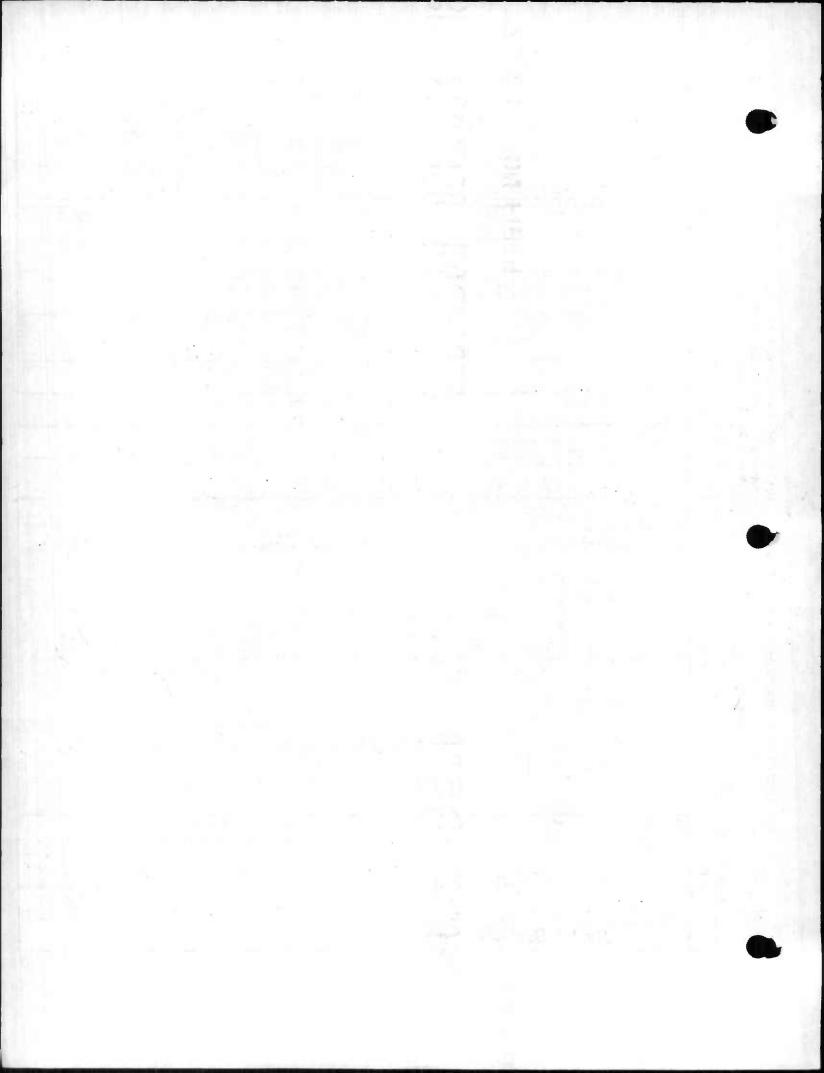
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within "4" hours after death. Page 6 may be retained by the restriction and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | | CE | RTIF | ICATE C | F DEAT | Ή | REG. N | 0. | | | |
|---------------|------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------|----------------|--------------------------|--------------------------|--------------|-----------------------------------|----------------|-------------------|-----------------|-------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | - | | 2. DATE OF DEATH | | | 3. TIME OF D | DEATH |
| | JOSHUA | RUSSELI | L ABI | BOT | Γ | | | August 2 | 3 1995 | YEAR | 7:45 | p.m.m |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | NGE (in yrs. lest | birthday) | IF UNDER 1 YEA | A IF UNDER 2 | 24 HRS. 1 | 7. DATE OF BIRTH | | a. BIRTNI | PLACE (State of | |
| | 220-10-6651 | 1XXM 2 - F | 81 | YRS. | MONTHS DAY | 8 HOURS | MIN. | Oct. 27 | 1913 | Mary | land | |
| | 9a. FACILITY NAME (If not institution, give street | et and number) | | | 96. CITY, TOY | N OR LOCATIO | | | | NTY OF DE | _ | |
| E | 5559 East New Ma | rket Rd. | | | East N | ew Mar | ket | | | hest | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| H | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE | CITY |
| | Maryland Dor | chester | | F | East New Market | | | | | 1 | LIMITS? | |
| AL | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | 10g. CITI | | HAT COUNTR | |
| BY FUNERAL | 5559 East | | | 2 | 1631 | | U. | S.A. | | | | |
| 5 | | 12. WAS DECEDENT EV | | | 13. WAS | DECENDENT OF | F HISPANIC | ORIGIN? (Specify) | es or No- | 14. RACE | — American | Indian, |
| × | 1 Never Married 2 X Married 3 Widowed 4 Divorced | FORCES? 1 Y | | , | | | Specify: | Puerto Rican, etc.) | - 1 | Black, Specify | , White, etc. | |
| | 3 Widowed 4 Divorced | | | | | | | | | | whit | e · |
| COMPLETED | 15. DECEDENT'S EDUCA' (Specify only highest grade co | rion mpleted) | 16a. DEC | EDENT'S | USUAL OCCUP | ATION most of working | , | 16b. KIND OF 8 | USINESS/INC | USTRY | | |
| 9 | Elementary/Secondary (0-12) | | Give kind of work done during most of working No. Do NOT use retried.) iilding contractor | | | | | | | | | |
| ₩ | 12 | | Dul | Tain | ig cont | | | | f empl | oyed | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) George W | ashington | Abbo | t t | | 18. MOTNI | ER'S NAME | (First, Middle, Meidle Lola Hi | n Sumame) | | | |
| BE | | dSillington | | | | | | | | | | |
| 2 | Mrs. Betty H. Abb | ott | 19b. | MAILING 550 | Foot M | et and Number of | or Rural Rou | Rd., East | wn, State, Zip | Code) | o+ MD | 21631 |
| . | | OLL | | | | | Ket I | | | | | 21031 |
| | 20a. METHOD OF DISPOSITION 1 ■ Burlel 2 □ Cremation 3 □ Remove | ni from State | pemetery, crays | atory or p | of disposition larket | (Name of | 0 | DATE 200. I | OCATION — | | | 1 |
| | 4 Donation 5 Other (Specify) | | East N | ew r | | AND ADDRESS | | | st New | Mari | ket Ma | arylan |
| | | 2 Thomas | a. | | | mas Fu | | | | | | |
| | I ennett to | - Juens | > () | | | | | Cambri | ige MD | 216 | 13 | |
| | 23. PART i. Enter the diseases, or cor shock, or heart failure. Lie | nplications that cau | vaed the deal | th. Do r | ot enter the | mode of dyln | ng, auch a | ea cardiac or rea | piratory arr | est, | Approx | |
| į | IMMEDIATE CAUSE (Final | ^^ | Ar decir line. | | | | | | | | | il Between and Death |
| | disease or condition - Metastatic Gastric Cancer 14 Month | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Z | Sequentially list conditions, b. | | | | | | | | | | | |
| Ĕ | If any, leading to immediate | | | | | | | | | | | |
| <u>3</u> | CAUSE (Disease or injury | | | | | | | | | | | |
| Ë | that initiated events resulting in death) LAST | DOE TO (OH) | AS A CONSEQU | JENCE OF | ·): | | | | | | | |
| CERTIFICATION | d | | | | | | | | | | | |
| | PART II. Other significant conditions | contributing to deal | th but not rea | eulting i | n the underly | ing cause gl | Iven in Pa | rt I. 24s. WAS A | N AUTOPSY | | WERE AUTOPS | |
| EDICAL | | | | | | | | PERF | ORMED? | | AVAILABLE PRI | |
| | | | | | | | | _ | - Kuo | | OF DEATH? | EN'NO |
| . M | DID TOBACCO USE CONTRIE | BUTE TO CAUSE | OF DEAT | H YE | s 🗆 NO | LINCE | ERTAIN | | | | 1 1 1 2 2 2 | III NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | H (Check only o | | 10771111 | | | | | |
| Sic | | IOSPITAL: | Outpatient 3 🗆 | DOA | OTHER: | ome 5 V Bee | Idanca & | Other (Specify) | | | | |
| ξ | 27. MANNER OF DEATH | 28a. DATE OF INJU | RY | 28b. T/M | E OF 28c. | INJURY AT | | 8d. DESCRIBE HOW | INJURY OCC | CURED | | |
| | 1 Natural 5 Pending | (Month, Day, Yei | Br) | INJ | M 1 { | WORK? | NO | | | | | |
| 84 | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJ | URY — At home | e, farm, s | treet, factory, o | ffice | 21 | 81. LOCATION (Stree | t and Number | or Rural Ro | oute Number | |
| COMPLETED | 4 Nomicide determined | building, etc. (| Specify) | | | | | City or Town, Stat | | | , | |
| ۳ | 29a. CERTIFIER (Check only | N: To the heat of my is | nowledge deat | h 0000000 | el el els els e | | 120 0 | | 20 C | | | |
| <u>F</u> | (Check only one) 2, MEDICAL EXAMINER: | | | | | | | | | | and decision | |
| | | A | | | m my opinio | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Bar | MO | | | 29c. LICEN | SE NUMBE | 2 () | 29d. DATI | BIGNED (| Month, Day, Ye | ier) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO O | COMPLETED CAUSE OF | TI (V | ATD /T | 0/ | 109 | Dd: | DY | Y | 150 | 95 | |
| | William Bai | 19 | | 1 - | Frint) | 6. | Com | noord | CAC | An O | 21 | 112 |
| - | 31. DATE FILED (Month, Day, Year) | 2. REGISTRAR'S S | TO | TILL | 11/1 - | | Cui | Ilbela | de | ev (t/ | dl | 613 |
| | AUG2 6 1995 | The Musel | Pull | , | | | | | | | | |

| BALTIMORE, MARYLAND 21215 | leath. Page 6 may be retained by the hospital or atten | funeral director name 5 should be detached for use as |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | ours after o | aft vd in better |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or atten | I DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as |
| ā | AL OF | A DIE |

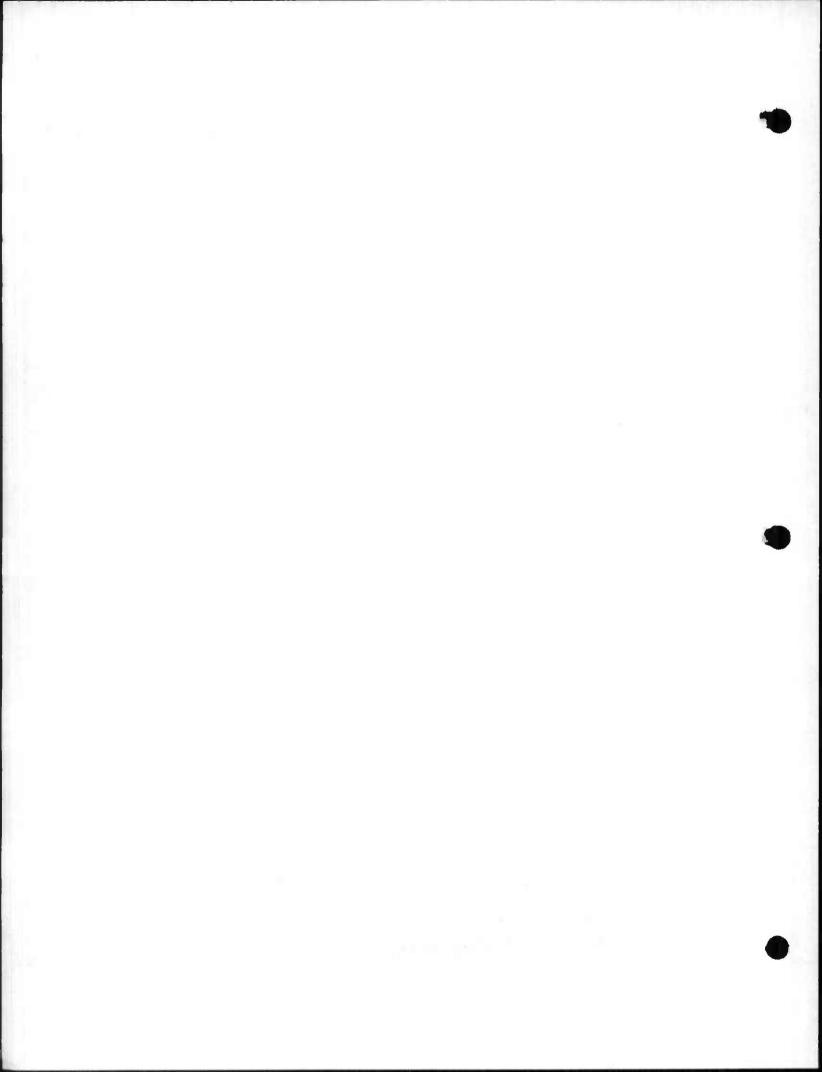
| | 1. DECEDENT'S NAME (First, Middle, Le | " A. ABE | - | | | 2. DATE OF DEATH DATE OF DEATH | | 3. TIME OF DEATH | | |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------|--|--|
| | 4. SOCIAL SECURITY NUMBER | 111 | E (In yrs. lest birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 7 95 8. BIR | ITHPLACE (State or Foreign | | |
| | 214-07-5787 | | 0.5 | | | Oct 27, 1 | 911 | intry) MD | | |
| Œ | 9a. FACILITY NAME (If not institution, git CUMBERLAND NURS | | | 96. CITY, TOWN C | OR LOCATION OF E | DEATH | ALLEGA | | | |
| CIC | RESIDENCE OF DECEDENT 10e, STATE 10b, COU | | len vi | | | | AUDIO | | | |
| DIRECTOR | | Legany | | ry, town on Local mberland | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| | 10e. STREET AND NUMBER | | 1 00 | | 10f. ZIP CODE | | | F WHAT COUNTRY? | | |
| FUNERAL | 65 Greene Stree | 12. WAS DECEDENT EVER | DIN HE ADMED | | 21502 | ANIC ORIGIN? (Specify Yes | USA | | | |
| B∀ | 1 Never Married 2 Married 3 Never Married 4 Divorced | FORCES? 1 TYE | FORCES? 1 TYES 2 X NO IF YES, GIVE WAR OR DATES | | | an, Puerto Rican, etc.) | Bi | NCE — American Indian, ack, Whita, atc. ecity: White | | |
| ETED | 15. DECEDENT'S E (Specify only highest gr | | S USUAL OCCUPATION Work done during moise retired.) | | 16b. KIND OF BU | SINESS/INDUSTRY | | | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | Homemaker ' | | | ome | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | ATHER'S NAME (First, Middle, Last) | | | | AME (First, Middle, Maiden | | | | |
| BE (| William Hend | erson | | | e (Kraus) | -5 | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti M. Scully Short Gap, WV 27667 | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town, State | | | | | | | | | |
| | 6 □ Donation 8 □ Other (Specify) _ | | Fort Ashb | other plece) ov Cemete | ery | 08/19 For | rt Ashby | , WV | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | , / | | NO ADDRESS OF F | | | | | |
| | 23. PART I. Enter the diseases, | + W/Can | Dell | Cambo | rland I | meral Home MD 21502 | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | S A CONSEQUENCE O | DF): | | | | Trimure | | |
| 100 | | | | | | | | | | |
| MEDICAL | PART II. Other significant condit | ions contributing to death | h but not resulting | In the underlyin | g cause given li | Part I. 24a. WAS AN PERFOI | RMED? | AWAILABLE PRIOR TO | | |
| MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | • | n but not resulting | 28. Pi | g cause given le | PERFOI | RMED? | COMPLETION OF CAUSE OF DEATH? | | |
| MEDICAL | 25. WAS CASE REFERRED TO MEDICAL | HOSPITAL: | outpetiant 3 00A | 28. PI | LACE OF DEATH (C | PERFOI t YES 2 | IMED? | AMAILABLE PRIOR TO COMPLETION OF CAUS: DF DEATH? 1 YES 2 NO | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TO 27. MANNER OF OEATH 1 Netural 5 Pending | HOSPITAL: 1 Inpettant 2 ER/O 28a. DATE OF INJUR (Month, Day, Year | butpetlant 3 🗆 OOA | 28. PI OTHER: 4 Nursing Hon ME OF 28c. IN. JURY WC | LACE OF DEATH (C | PERFOI | IMED? | AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | | |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 OO 27. MANNER OF OEATH 1 Netural 5 Pending | HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR building, etc. (S | outpatiant 3 00A | 28. PI QTHEFI: 4 Mureling Hon ME OF 28c. IN. WC M 1 | LACE OF DEATH (Come 8 Residence SURY AT PRES 2 NO | PERFOI t YES 2 | NJURY OCCURED | AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | | |
| ETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR building, etc. (S | Putpetlant 3 OOA IY 28b. Til IN IRY — At home, farm, pecify) | 28. PI OTHER: 4 Nursing Hon ME OF 28c. IN. JURY M 1 street, factory, officered at the time, data | LACE OF DEATH (Cone 8 Residence SURY AT DRK? YES 2 NO Dea | PERFOI t YES 2 inheck only one) 8 Other (Specify) 28d. DESCRIBE HOW a 28f. LOCATION (Street City or fown, State, see to the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cause(s) and make the cau | NJURY OCCURED and Number or Run | AMAILABLE PRIOR TO COMPLETION OF CAUS: DF DEATH? 1 YES 2 NO | | |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 □ Inpetiant 2 □ ER/O 28a. DATE OF INJUR (Month, Day, Year be be be be be be be be be be be be be b | outpetlant 3 OOA TY 28b. TH IN IRY — At home, farm, pocify) owledge, death occur witon and/or investigati | 28. PI OTHER: Nursing Hon ME OF JURY M 1 1 street, factory, office red at the time, data on, in my opinion, of | LACE OF DEATH (Cone 8 Residence SURY AT DRK? YES 2 NO Dea | PERFOL t YES 2 theck only one) 8 Other (Specify) 28d. DESCRIBE HOW 1 28f. LOCATION (Street City or fown, State, et to the cause(e) and make time, data and place, as | NJURY OCCURED and Number or Run nner as stated, ad due to the cause | AMAILABLE PRIOR TO COMPLETION OF CAUS: DF DEATH? 1 YES 2 NO | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Ye wours after death. Page 6 may be retained by the hospital or attending physician. | RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 2 3 should | be fied within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | m 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--|
| TO THE HOSPITAL OR ATTENDING PHYSIC | TO THE FUNERAL DIRECTOR: After this co | be filed within 72 hours after death with t | IMPORTANT: If Item 28 is marked, | |

| | 1 - STATE OF MARYLA | ND / DEPARTME | NT OF HEALTH AN TE OF DEATH | D MENTAL HYGIEN | | | | | | |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------|------------------------------|----------------------|-------------------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Blanche Berkner | | | August 6 | - 0.0= | 6:30A H | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (II | yrs. last birthday) IF UM MONTH | DER 1 YEAR JF UNDER 24 HP | 44.4 M B 14.4 | 8. BIRTH Countr | PLACE (State or Foreign | | | | |
| | 153-05-0407 1 M 2 X F S | 86 YRS. | S DAYS HOURS MH | February 12, | 1000 | many | | | | |
| DIRECTOR | 25231 Adams Landing Road | | Denton | Caroline | | | | | | |
| REC | 10a. STATE 10b. COUNTY | 10c, CITY, TOW | N OR LOCATION | | | 10d. INSIDE CITY | | | | |
| | Maryland Caroline | I | enton | | | 1 YES 2 NO | | | | |
| FUNERAL | | | 101. ZIP CODE | | 10g. CITIZEN OF W | | | | | |
| N. | 25231 Adams Landing Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN | U.S. ARMED | 21629 | PANIC ORIGIN? (Specify Yes | U.S.A. | | | | | |
| BY FL | 1 Never Married 2 Married FORCES? 1 YES 3 Widowed 4 Divorced FORCES? 1 YES | 2 NO | | xican, Puerto Rican, etc.) | Black Species | - American Indian, t, White, etc. | | | | |
| | | | | | | asian | | | | |
| ETE | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | 16a. DECEDENT'S USUAL (Give kind of work do. life. Do NOT use retire. | ne during most of working | 16b. KIND OF BUS | HNESS/INDUSTRY | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | Homema | | | Home | | | | | |
| Š | 17. FATNER'S NAME (First, Middle, Last) | | | NAME (First, Middle, Meiden | | | | | | |
| BE (| Antoine Barbier | | | na Augustine | | ue | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Arthur K. Berkner | | | Pond Donks | | and 21620 | | | | |
| | 20s. METNOD OF DISPOSITION 20h | PLACE AND DATE OF DISP | | Road, Dento | CATION - City or To | | | | | |
| | D☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State ceme | tery, cremetory or other place | on Memorial Par | | mus, New Je | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 2. NAME AND ADDRESS OF | FACILITY | | 100 | | | | |
| | () anderly. (1 | 10012 | | ral Home, P. B. Denton, M | | 21629 | | | | |
| | 23. PART I. Enter the disesses, or complications that caused shock, or heart failure. List only one cause on ea | the death. Do not an | ter the mode of dying, | such as cardiac or respin | ratory strest, | Approximats | | | | |
| | ************************************** | | | | | Interval Batween Onset and Death | | | | |
| | disease or condition - a. CEREBROVASCUIAR ACCIDENT ACCIDENT ACCIDENT | | | | | | | | | |
| z | Sequentisity list conditions, Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | CONSEQUENCE OF): | | 1300000 | a lac -se | - CIT. OTTE | | | | |
| | CAUSE (Disesse or Injury C. | CONSEQUENCE OF: | | | | | | | | |
| | resulting in desth) LAST | , | | | | | | | | |
| | PART II. Other significant conditions contributing to death but | t not resulting in the | undarfulna causa aluen | In Part I. 24s. WAS AN | ALITADON DAIL | WERE AUTOPSY FINDINGS | | | | |
| CAL | DIABPLES MEllitus | | underlying cause given | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| E I | PART II. Other significant conditions contributing to death by DIABETES MELLITUS PREVIOUS CELEGIOVE | SCULAR | Accide | YES 2 | NO NO | OF DEATH? | | | | |
| PHYSICIAN: MEDIC | | | | | | 10 120 10 10 | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | ОТН | 26. PLACE OF DEATN | (Check only one) | | | | | | |
| 1YS | 1 ☐ YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpa 27. MANNER OF OEATN 28e. DATE OF INJURY | tient 3 DOA 4 DA | lursing Home 5 Residen | | | | | | | |
| | 1 Natural 5 Pending (Month, Day, Year) | INJURY M | WORK? | 28d. DESCRIBE NOW IN | JURY OCCUREO | | | | | |
| ED BY | building ate /Specif | - At home, farm, street, f | | 28f. LOCATION (Street et | nd Number or Rural R | oute Number, | | | | |
| ETE | 4 Homicide determined | ,, | | City or Town, State) | | | | | | |
| COMPLET | 29e. CERTIFIER Check only one) DEFINITION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE DESTRUCTION OF THE | | | | | | | | | |
| | 2 MEDICAL EXAMINER: On the basic of examination | end/or investigation, in m | | | | | | | | |
| BE (| (Mensey. MO | | 29c, LICENSE | 664 | DATE SIGNED | (Month, Day, Year) | | | | |
| 임 | 36. HAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEAT | TH (ITEM 27) (Type, Print) | | | -11 | /3 | | | | |
| | Christian E. Jensen, M.D., PC | | Denton, Mary | yland 21629 | | | | | | |
| | 31. DATE FILED (Month, Dey, Year) AUG = 8 95 32. REGISTRAR'S SIGNAL Gulia Davidson | | | | | | | | | |
| | AUG - 8 '95 Gulia Davidson | 1-Handele | | | | | | | | |



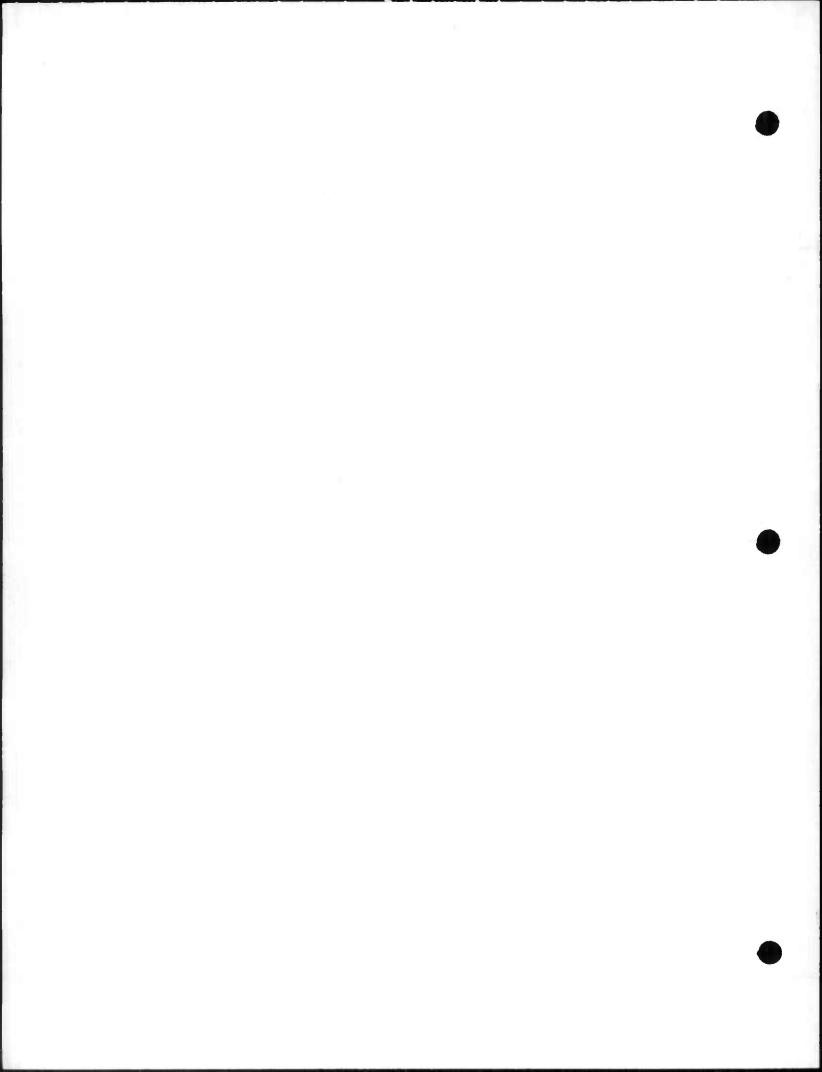
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Ilem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

| | + DECEDENT'S NAME (FINA | 1.41-4-11- 1 A | | | | IOAII | - 01 | DEA | | HEG. I | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------|--------------------------------------------------------------------|------------|------------------------------------------|--------------------------------------|--------------|-------------------------------------------|
| | t. DECEDENT'S NAME (First | th | L. | | | Be | ave | n - | 4 | 2. DATE OF DEATH MONTH | DAY | 995 | 3. TIME OF DEATH 1:45 PM |
| | 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER | | 4 | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTH | IPLACE (State or Foreign |
| | 219-36-6379 |) | 1 □ M 2 📆 F | 89 | YRS. | MONTHS | DAYS | HOURS | MIN. | July 24, | 1906 | Mat | yland |
| | 9e. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | r, TOWN | OR LOCATI | ON OF DI | | | JNTY OF D | |
| 8 | Memorial Ho | spita] | L | | | 1 | East | on | | | T | a1bot | |
| DIRECTOR | RESIDENCE OF DEC | 10b. COUNT | | | | | | | | | | | |
| = | | | | | 10c. CITY, TOWN OR LOCATION | | | | | 10d. INSIDE CITY LIMITS? | | | |
| | Maryland 100. STREET AND NUMBER | Caro | Line | | Hillsboro | | | | | | 1 YES NO | | |
| FUNERAL | | | | | | | 10 | f. ZIP COO | | 10g. CITIZEN OF | | | 2017 |
| W W | 11126 Tucka | thoe Ro | | | y Just | | | 2. | 1641 | | | U.S. | Α. |
| 5 | 1 Never Married 2 | Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | S. ARMED 13. WAS DECENDENT OF HISPANIC 15. WAS DECENDENT OF HISPANIC 16. WAS DECENDENT OF HISPANIC 17. WAS DECENDENT OF HISPANIC 18. WAS DECENDENT OF HISPANIC 19. WAS DECENDENT OF HISPANIC 19. WAS DECENDENT OF HISPANIC | | | IC ORIGIN? (Specify Yee or No — 14. RACE n, Puerto Rican, etc.) | | | — American Indian, c, White, etc. | | |
| B | 3X Widowed 4 Divo | | IF YES, GIVE W | AR OR DATES | | | | y: | | Speci | | | |
| 8 | 15. DEC | EDENT'S EDU | CATION | 16a DE | CEDENT'S | USUAL O | CCUPATION | ON | | 16b. KIND OF | DI IĈINEGO (IN | | asian |
| E I | (Specify onl | y highest grade | College (1-4 or 5 - | (G | he kind of a Do NOT us | work done | during mo | ost of working | ng | NO. KIND OF | DOSINESS/IN | DUSINI | |
| 립 | 11 HS gra | | 2 | | Teach | ner | | | | F | ducat | ion | |
| COMPLET | 17. FATHER'S NAME (First, M | | | | 10001 | 101 | | 18. MOT | HER'S NA | ME (First, Middle, Mak | | LOII | |
| Ш | Joh | n H. | Lucas | | | | | | E1: | | | | |
| m | 19e. INFORMANT'S NAME (1 | ype/Print) | | 190 | b. MAILING | ADDRES | S (Street a | and Number | or Rural I | Route Number, City or | fown, State, Z | ip Code) | |
| 유 | Margaret B. | Eve1a | and | | | | | | | Cordova, | | | 21625 |
| | 20e. METHOD OF DISPOSIT | | and form the . | 20b. PLACE | AND DATE | OF DISPOS | SITION /Ne | ame of | 3- | | LOCATION - | | wn, State |
| | 4 Donation 5 Other | (Specify) | ** | St. Pa | aul's | ther place) Cen | nete: | ry | ž | 8/21 H | illsb | oro, | Maryland |
| П | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | |
| | Moore Funeral Home, P.A. PO Drawer B. Denton, Maryland 21629 | | | | | | | | | | | | |
| П | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | |
| | shock, or heert fallure. List only one cause on each line. Interval Between Onset and Death | | | | | | | | | | | | |
| ш | | | | | | | | | | | | | |
| 1 1 | resulting in death) a. Objection of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequenc | | | | | | | | | | | | |
| z | Sequentially list conditions, Fracture rt. Genur 07-16-95 | | | | | | | | | | | | |
| 일 | Sequentially list conditi if any, leading to imme | IIII Odleta | | | | | | | | 01-16-13 | | | |
| 2 | cause. Enter UNDERLY! CAUSE (Disease or Inju | | c | | | · | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAS | | DUE TO | (OR AS A CONSEC | DUENCE OF | F): | | | | | | | |
| 馬 | | | d | | | | | | | | | | |
| 4 11 | PART II. Other algnifica | nt condition | a contributing to | death but not r | eaulting i | in the ur | derlyln | g ceuae g | given in | Part I. 24s. WAS | AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| DICAL | Hype | reten | sive c | vidio | va | سمع | Qu | z de | sea | PERF | 2 TV NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| W | , 8, | | | | | | | | | 1 1 123 | 2 LIF NO | | OF DEATH? |
| 2 | DID TOBACCO U | SE CONTI | RIBUTE TO CA | USE OF DEA | TH YE | S 🗆 I | NO [| UNC | ERTAIN | v 🗆 | | | , |
| SIAI | 25. WAS CASE REFERRED TO EXAMINER? | | | | E OF DEAT | | | | | | | | |
| PHYSICIAN: | t TYES 2 NO | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER | | e 5 🗆 Re | sidence | 6 Other (Specify) | | | |
| E | 27. MANNER OF DEATH | | 28e. DATE OF (Month, Di | | 28b. TIM | E OF URY | 26c. INJ | URY AT | | 28d. DESCRIBE NO | OO YRULNI V | CURED | |
| BY | | Pending Investigation | | ,, ,, | | М | | YES 2 | ON [| | | | |
| | 3 Sulcide 6 | Could not be | 28e. PLACE O building, | F INJURY - At ho | me, ferm, s | street, fect | ory, offic | • | | 261. LOCATION (Stre City or Town, Str | | r or Rural R | oute Number, |
| | 4 Homicide | determined | | | | | | | | 5.7, 5. 15.1.1, 5.1 | , | | |
| P | 29e. CERTIFIER (Check only | IFYING PHYSI | CIAN: To the best of | my knowledge, de | eth occurre | d at the t | ime, date | end place | , end due | to the cause(e) end r | nanner as sta | ted. | |
| COMPLET | | | | | | | | | | | | | end manner ee stated. |
| U U | 29b. SIGNATURE AND TITLE | OF CERTIFIER | | | | | | 29c. LICE | NSE NUN | 18ER | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 00 | Rober | tw. | Tireve- | C, M. J | | | | D | 109 | 38 | 10 | ina | 17 1995 |
| 2 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUS | E OF DEATN (ITER | 1 27) (Type, | Print) | | | | | | - | -14110 |
| | Robert W. T | rever | M.D., 7 | 696 Oce | an Ga | atewa | ay, | East | on, l | Maryland | 2160 | 1 | |
| | 31. DATE FILED (Month, Day, | | | R'S SIGNATURE | | | | | | | | | |
| | AUG 21 | 95 | Gulia D | avidson B | ndino | | | | | | | | |
| | | | U | | | | | | | | | | DHMH-18 Rev 1/89 |

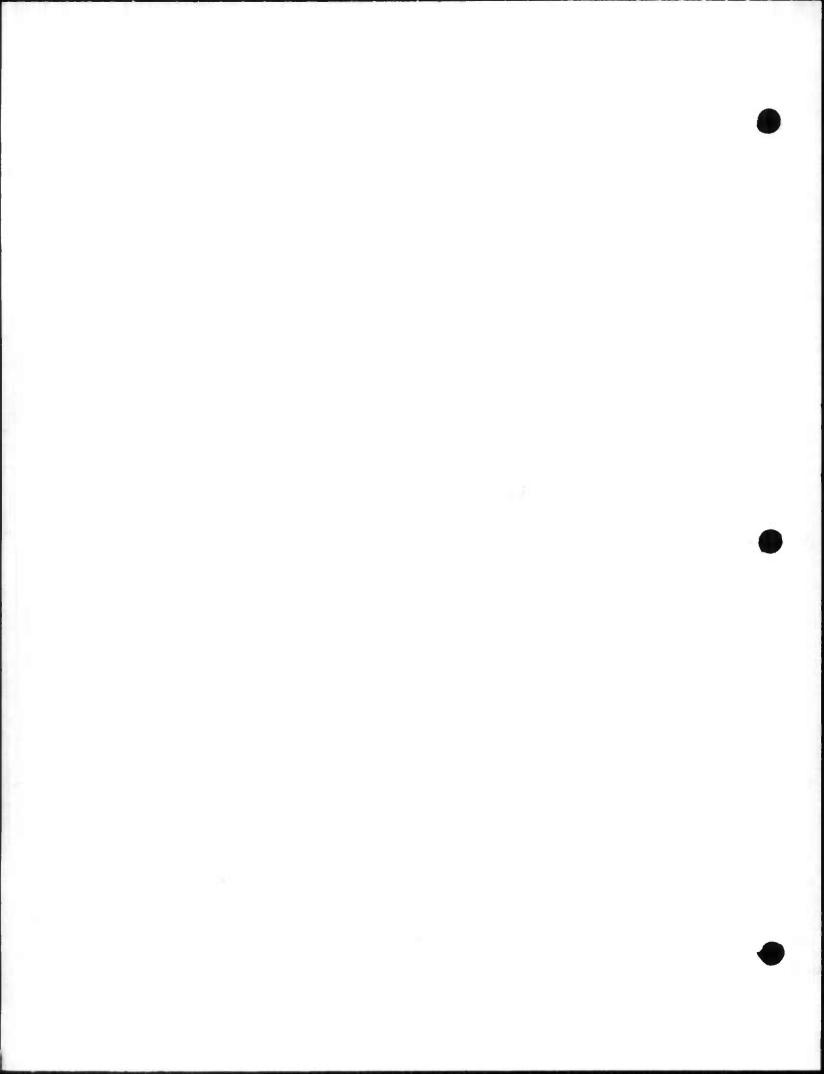


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| all) | |

Pages 1, 2, 3 should DIRECTOR 10a. STATE permit. FUNERAL 10e. STREET AND NUMBER ure orean ceruincate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mygiene prior to burial, cremation, or removal. 2735 Karen 11. MARITAL STATUS 1 Never Married 2 Merried BY 3 Widowed 4 Divorced ETED (Specify only high Elementary/Secondary (0-12) 19a. INFORMANT'S NAME (Type/Print) 9 requires that the death certificate be executed within 24 hours after death. IMMEDIATE CAUSE (Final disease or condition reaulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in deeth) LAST PHYSICIAN: MEDICAL has been signed by the Dept. of Health and P 23 DR ATTENDING PHYSICIAN: The law this certificate h 1 YES 2 NO 0 27. MANNER OF DEATH marked. 1 Natural BY After t 2 Accident 3 Suicide 28 is COMPLETED DIRECTOR: / 4 Homicide 29e. CERTIFIER TO THE HOSPITAL D TO THE FUNERAL DI be filed within 72 ho (Check only one) BE 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 1995 PHILLIP ELWOOD AUG BAKER 27 3:10 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) of b. h. Day. h. 13, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 K M 2 - F DAYS HOURS 216-64-3501 YRS 40 July 1955 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2735 Chesapeake Beach, MD Karen Calvert RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Calvert Chesapeake Beach 1 YES 2 1 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Drive 20732 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yea, specify Cuben, Maxican, Puerto Rican, etc.)
 □ YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1974 - 1980white 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) painter, paper hanger construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Jack Elwood Baker Emma Beatrice Reynolds 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy Baker same as # 10 above 20e. METHOD OF DISPOSITION
1 № Buriel 2 □ Cremetion 3 □ Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State MD Veterans Cemetery 4 Donation 5 Other (Specify) 8-30-95 Cheltenham, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, PA, Owings, MD 23. PART i. Enter the diseeses, or icetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. only one cause on each line. intervai Between Onest and Death trus Lynphone toole 5 dronod DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF) PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED M 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building. atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 1 📝 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner ea stated. 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTI 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Hear) PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

19 C Lesa pegles (CL/gm 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE · Sander Rardall 2 9 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| DALIMORE, MARILAND 21213-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | the medical examiner must be notified at once. | |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furble filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPAI CERTIF | RTMENT OF | HEALTH AND | MENTAL HYGIEN | E | | | |
|-------------|-------------------------------------------------------|----------------------------------------------------------|---------------------------------|----------------------|---------------------------------------------------------------|----------------------------|-------------------|-------------------------------------------|--|--|
| | t. DECEDENT'S NAME (First, Middle, La | ast) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | EVELYN | CLAYBROO | K BOWI | E | | AUGUST 20 | | | | |
| | 4. SOCIAL SECURITY NUMBER | | E (in yrs. last birthday) | IF UNDER I YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or For | | | | | |
| | 213-74-0368 | 1 🗆 M 2 🛣 F | 88 YRS. | MONTHS DAYS | HOURS MIN. | | | | | |
| | 9a. FACILITY NAME (If not institution, gi | ve street and number) | | 9b. CITY, TOWN | OR LOCATION OF D | | 9c. COUNTY OF | | | |
| ä | MEMORIAL HOSPITA | L & MEDICAL (| ENTER | CUMBERL | | | ALLEG | | | |
| 5 | RESIDENCE OF DECEDENT | | 22112211 | TOURDERE | HIVD | | ALLEG | FANI | | |
| DIRECTOR | 10s. STATE 10b. COU | INTY | 10c. CI | TY, TOWN OR LOCA | TION | | | 10d. INSIDE CITY | | |
| | | LEGANY | | CUMBERI | AND | | | 1 X YES 2 NO | | |
| ₹ . | 10s. STREET AND NUMBER | | | 10 | H. ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | |
| FUNERAL | 706 WASHING | | | | 21502 | | | | | |
| 3 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YE | IN U.S. ABMED | 13. WAS DE | CENDENT OF HISPAN | NIC ORIGIN? (Specify Yes | or No- 14, RA | CE — American Indian, ick, Whita, atc. | | |
| 8 | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | | 3 2 X NO Specifi | | | WHITE | | |
| | 15. DECEDENT'S E | FOUCATION | 14- DECEDENT'S | S USUAL OCCUPATI | 041 | 16b, KIND OF BUS | | MHILE | | |
| COMPLETED | (Specify only highest gi | rade completed) | (Give kind of | work done during m | ost of working | 160. KIND OF BUS | HNESS/INDUSTRY | | | |
| P. | Elementary/Secondary (0-12) | College (t-4 or 5+) | | MAKER | | OWN | HOME | 1 | | |
| M C | 17. FATHER'S NAME (First, Middle, Last) | | HOLLE | III KIJI | 10 MOTHER'S NA | ME (First, Middle, Maiden | | | | |
| | | B. CLAYBRO | O K | | | T LIGHTF | | 1 | | |
| 8E | 19a. INFORMANT'S NAME (Type/Print) | | | ADDRESS /Street | The second second | Route Number, City or Town | | | | |
| 2 | GORDON L. BO | WIE | | | | , CUMBER | | MD 21502 | | |
| | 20a. METHOD OF DISPOSITION | , | 0b. PLACE AND DATE | | | | CATION — City or | | | |
| | 1 Donation 6 Other (Specify) | amoval from State | emetery cometory or | other piecel | | | | | | |
| | 21. SACHATUME OF FUNERAC SERVICE | LICENSEE | SILDAUG | 22. NAME A | ND ADDRESS OF FA | 22/95 UN | TONTOW | N, PA | | |
| | | 1 4 | 7. | | | | HILLS | MORTUARY | | |
| | Complea | - 1100 | ten | 1302 | NATION | IAT. HWY | TA VAL | E.MD 21502 | | |
| | 23. PART i. Entar the diseases, shock, or hasrt fallu | or complications that caus re. List only one causs on | ed the death. Do each line. | not anter the me | ode of dying, such | h as cardiac or respi | ratory arrest, | Approximate interval Batween | | |
| | IMMEDIATE CAUSE (Final | N 1/= | | | | | | Onset and Death | | |
| | disesse or condition resulting in death) | CHA | | | | | | | | |
| | | DUE TO (OR AS | A CONSEQUENCE O | OF): | | | | 11 | | |
| z I | Sequentially list conditions, | - a Mutral | Require | - | | | | 44co15 | | |
| RTIFICATION | If any, lasding to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEQUENCE D | OF): | | | | 4 years | | |
| 2 | CAUSE (Disesse or injury | C | A COMPENSATION OF | | | | | 4 years | | |
| | that initiated eventa resulting in death) LAST | DOE TO (OR AS | A CONSEQUENCE O | PF): | | | | | | |
| | | d | | | | | | | | |
| AL | PART II. Other significant condit | iona contributing to death | but not reaulting | | g ceuse given in | Part I. 24a. WAS AN | | Ib. WERE AUTOPSY FINDINGS | | |
| | Hep 1 | raeture | | 2 month | 5 | PERFOR | - | AVAILABLE PRIOR TO COMPLETION DF CAUSE | | |
| VEDIC | 1 / | | | | | | | OF DEATH? | | |
| Σ | DID TOBACCO USE CON | TRIBUTE TO CAUSE | OF DEATH Y | ES NO [| UNCERTAIN | <u> </u> | | 1 1E5 2 NO | | |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | TH (Check only one) | 3 OTTEERITAI | | | | | |
| | EXAMINER? | HOSPITAL: | strationt 3 DOA | OTHER: | ne 5 🗆 Rasidenca | a [] Albert (0-1-14.) | | | | |
| | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b, Till | AE OF 26c. IN. | JURY AT | 26d. DESCRIBE HOW IP | JURY OCCURED | | | |
| 1 | 1 Natural 5 Pending | (Month, Day, Year) | IN. | JURY WO | YES 2 NO | | | | | |
| B4 | 2 Accident Investigation 3 Suicide & Could not | 28e. PLACE OF INJUS | RY — At home, farm, | | | 28f. LOCATION (Street a | nd Number or Rure | I Anuto Number | | |
| E | 4 Homicide determined | building, etc. (Sc | ecify) | | | City or Town, State) | | 110010 11011001 | | |
| 4 | 29a. CERTIFIER | VRICIANI, To the territory | | | | | | | | |
| COMPLE | | YSICIAN: To the best of my kno | | | | | | | | |
| 3 | - Commission | INER: On the basis of examinet | The second second second second | on, in my opinion, (| reach occurred at the | time, data end place, end | gua to the cause | (s) and manner as stated. | | |
| N N | 296. SIGNATURE AND TITLE OF CENTRE | MIN / | | | 29c. LICENSE NUN | IBER | 29d. DATE SIGNE | D (Month, Day, Year) | | |
| 2 | 170 Mer | m. | | | D 2891 | 0 | AUGUS' | 12/1995 | | |
| | 30. NAME AND ADDRESS OF PERSON | | | | | | | | | |
| | DR. H.C.MERRICK | | L AVE., C | UMBERLAI | ND, MD | 21502 | | | | |
| | AUG 2 2 1995 | FILL COMMING | HAIDRE | | | | | | | |
| | #1117 to 20 1000 | a | | | | | | | | |

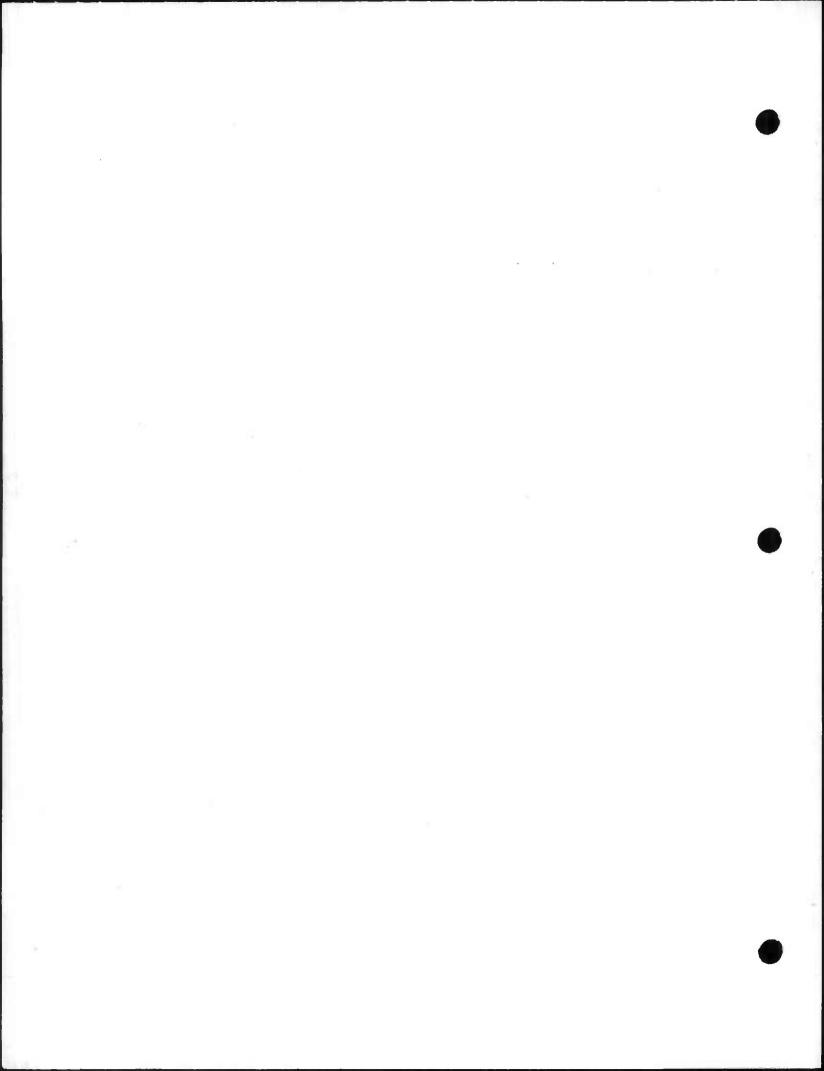
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------|---------------------|--------------------------------------------------------------------------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) RUBY B | OND | BRENNAN | | 2. DATE OF DEATH | AY YEAR | 3. TIME OF DEATH | | | | | |
| ~ | 4. SOCIAL SECURITY NUMBER 220-10-4550 9a. FACILITY NAME (If not institution, give atm | 1 M 2 F | 78 YRS. MONT | HE DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Feb. 28 | e pip | THPLACE (State or Foreign not) TYPY Virginia | | | | | |
| СТО | Sacred Heart Host RESIDENCE OF DECEDENT 100. STATE 100. COUNTY | oital | | Cumberland ON OR LOCATION | | Allegany | | | | | | |
| FUNERAL DIRECTOR | Sarvland Alleg | gany | Barto | on | | | 10d. INSIDE CITY LIMITS? YES 2 NO | | | | | |
| VERA | Box 104, Tempe | | | 101. ZIP CODE 21521 | | | States | | | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 2 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 (80 | (RO It yes, specify Cuban, Maxican, Puerto Rican, | | | CE — American Indian, ck, White, etc. Indite | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5 +) | 16e. DECEDENT'S USUA (Give kind of work do life. Do NOT use retire | one during most of working | 16b. KIND OF BU | SINESS/INDUSTRY | | | | | | |
| MP | Unknown 17. FATHER'S NAME (First, Middle, Last) | | Home Car | | Heal | | | | | | | |
| Ö | George H. Boyce | | | | AME (First, Middle, Maiden Boyce | Surname) | | | | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDR | ESS (Street and Number or Rural | | n, State, Zip Code) | | | | | | |
| ۴ | Charles W. Brenna | | Box 10 | 4, Temperance | Row, Bart | on. Md. | 21521 | | | | | |
| | 20e. METHOD OF DISPOSITION 1 V Burlal 2 Cremation 3 Remote 4 Donation 5 Other (Specify) | val from State 20b. | PLACE AND DATE OF DIS | POSITION (Name of elis Cem. 8 | -21-95 B. | earton. M | Town, Stata | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | SLAGABET | ers cem. 22 NAME AND ADDRESS OF F Boar Funeral | ICILITY | GI 0011, 11 | | | | | | |
| | · Ways | 12 502 | 1 | 111 Church S | t. Western | | . 21562 | | | | | |
| NOI | 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory strest, above, or heaft failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Cardiac Asystole DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, fir any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initied eventa resulting in death) LAST | | CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL | PART II. Other algorificant conditions Higher fees ion DID TOBACCO USE CONTRI | Charie of | Structive | lung discase | PERFOR | RMED? | b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | 6. PLACE OF DEATH (Chi | | | | | | | | | |
| Sic | | HOSPITAL: | tient 3 DOA 4 D | IER: Nursing Home 5 Residence | 6 Other (Specify) | | | | | | | |
| ву Рн | 27. MANNER OF DEATN 1 Naturel 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c, INJURY AT WORK? 1 YES 2 NO | 28d. DEŞÇRIBE HOW I | NJURY OCCURED | | | | | | |
| | 3 Suicide 6 Could not be datarmined | 26e. PLACE OF INJURY building, atc. (Special | At home, farm, street, | tactory, office | 26t. LOCATION (Street a City or Town, State) | and Number or Rural | Floute Number, | | | | | |
| COMPLETED | | | | ne time, data and place, and due ny opinion, death occured at the | | | (a) and manner as stated. | | | | | |
| BEC | 29b. SIGNATURE AND THE OF CENTIFIER | 100 | | 29c, LICENSE NU | A770711 | 29d. DATE SIGNE | D (Month, Day, Year) | | | | | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TN (ITEM 27) (Type, Print) | esles Ave | 1.0200 | AUGUST | | | | | | |
| | 31. DATE FILED (Month, Day, Year) All C 2 2 1995 | 32. MEGISTRAR'S SIGNA | TURP (- Kardall | 7120 1/05 | 00-646011 | y, ord | C1339 | | | | | |

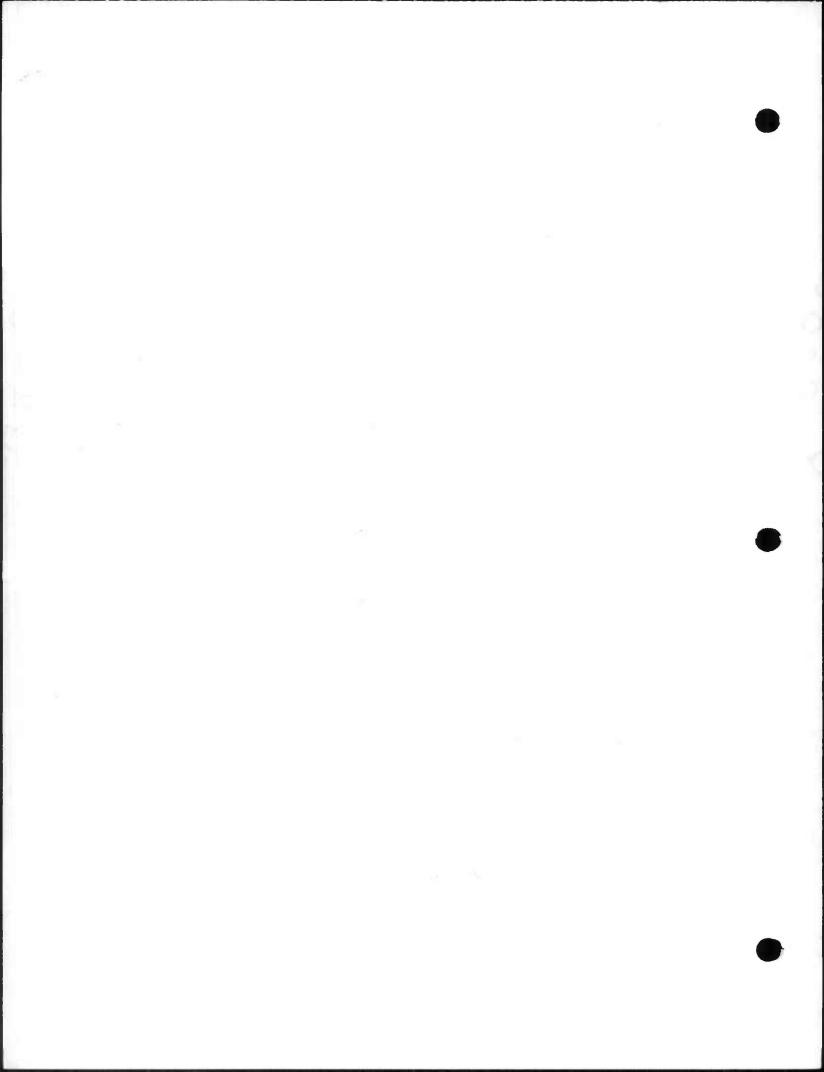


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | | HEALTH AND | MENTAL HYGIEN | _ | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------|-------------------------|------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Reging | Baker | | | 2. DATE OF DEATH MONTH D | AY YE | 3. TIME OF DEATH |
| | 212 01 9627 | 1 □ M 2 💢 F 82 | (In yrs. last birthday) YRS. | IF UNDER 1 YEAR | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 27,19 | 1 1 | BIRTHPLACE (State or Foreign Country) ENNSYLVANIA |
| OR | 9e. FACILITY NAME (If not institution, give stree FROSTBURG VILLAGE | | OME | | N OR LOCATION OF D TBURG | EATN | 9c. COUNTY ALI | OF OEATN LEGANY |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | CATION | | | tod. INSIDE CITY LIMITS? | | |
| ERAL D | 10e. STREET AND NUMBER | EGANY | M | IT. SAV | 10f. ZIP CODE | | | t ☐ YES 2 📉 NO OF WNAT COUNTRY? |
| BY FUNE | PATTY BAKER HI 11. MARITAL STATUS 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | ILL 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D. | 2 NO | If yes, | 2154. ECENDENT OF HISPAI specify Cuban, Maxics ES 2 XNO Specific | NIC ORIGIN? (Specify Yea in, Puerto Rican, atc.) | | S.A. RACE — American Indian, Black, White, etc. Specify: |
| ETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co | TION empleted) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of a life. Do NOT us | USUAL OCCUPA work done during se retired.) | TION most of working | 16b. KIND OF BUS | BINESS/INDUST | WHITE |
| COMPL | 8 17. FATHER'S NAME (First, Middle, Last) | | SEAMSTR | RESS | 16. MOTHER'S NA | SHIRT I | | |
| BE | JOHN SPURNO 19a. INFORMANT'S NAME (Type/Print) | | 10h MAII INC | ADDRESS (C) | | RY RUMANSC | | |
| 2 | PATRICIA ROBISON | | 159 FC | UNDRY | ROW ST., | NW, MT. SAY | VAGE, N | ID 21545 |
| | 20a. METHOD OF DISPOSITION 1 To Burlal 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | al from State 20b cen | netery, cremetory or or MICHAF | ther nlecel | | 1 | CATION — CHY FROSTBU | |
| | ST. MICHAEL'S CEMETERY, AUG. 21, 1995, FROSTBURG, MD 21532 22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 | | | | | | | 21532 |
| N | 23. PART/I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in desth) 3. DUE WIOR AS A CONSEQUENCE OF W. | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Sylons | |
| MEDICAL | PERFORMED? 1 YES 2 NO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | | | | | | | COMPLETION OF CAUSE DF DEATH? |
| HYSICIAN: | DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEAT | H (Check prily or | | N 🔲] | | |
| I V | | 1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) | | | | | | |
| 2 | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) INJURY WORK? M 1 YES 2 NO | | | | | | |
| LEIED | 3 Suicide 6 Could not be 4 Homicide determined | | | | | | | |
| OMPLE | | N: To the best of my know. On the basis of examination | | | | | | use(a) and manner as stated. |
| וח מב ר | and title of certifier | with. | mp | | Da 4 | 1951 | 29d. DATE-GIO | SNED (Mogth, Dyr.) |
| | 31. DATE FILED (Month, Day, Year) | 1. MD 4 | STARN | - market | ACE, 1 | TRUSTBURG | i.ml | 21532 |
| | ALIG 2 2 1995 | Jalia Warris | Mardall | | | | | |



Pages 1, 2, 3 should

permit.

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director case 5 should be detached for use as the hurdal-transit | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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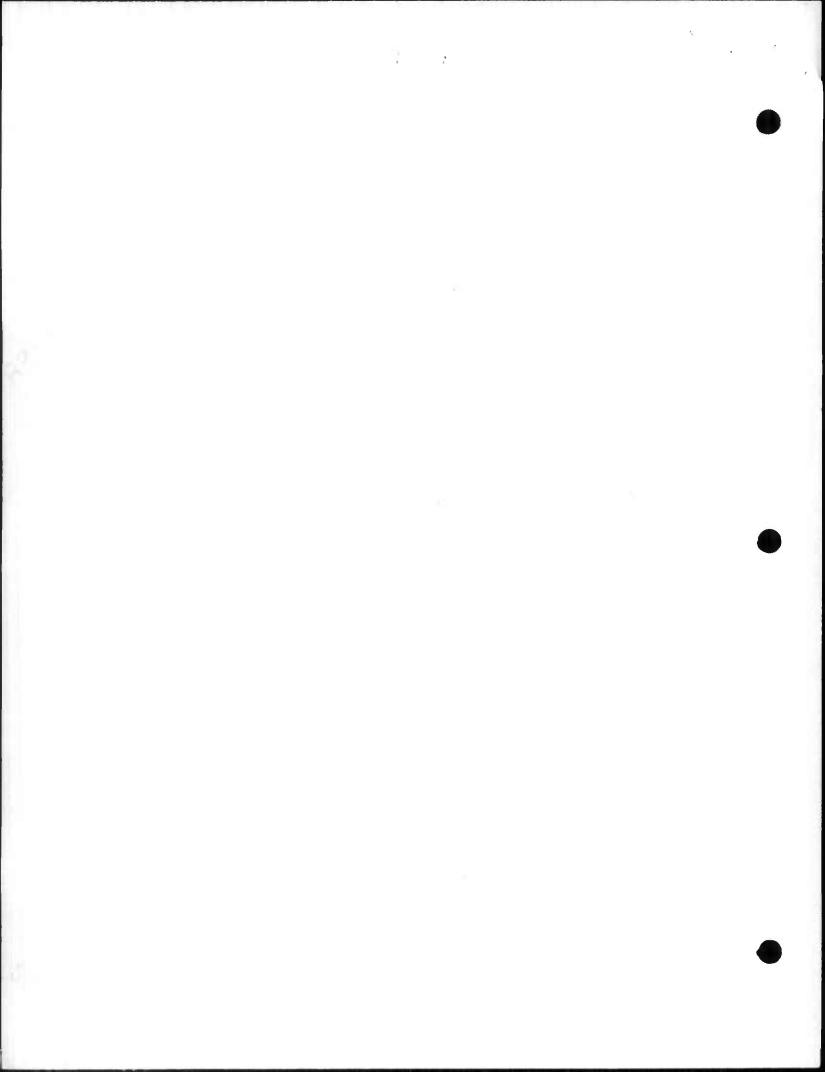
95 27407 AMENDED #16a., 8/28/95, B.P., WORCESTER CO. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH urbage Jugust Matilda Trimper 7:55 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 1/6/18 IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 X F 77 YRS 577-30-7293 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Worcester 1 XYES 2 NO Ocean City 10a. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WNAT COUNTRY? 711 Baltimore Ave. 21842 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married s, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2000 Specify: Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (t-4 or 5+) Ownwer/Operator Apartment Tourism 11 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) 10 Harry Yarborough BE Katherine S. Trimper notified 19e. INFORMANT'S NAME (Type/Print, 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 William Burbage 711 Baltimore Ave. Ocean City, MD 9 20a, METHOD OF DISPOSITION
1 Deviat 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Evergreen Cemetery 4 Donation 5 Other (Specify) 8/30/95 Berlin, MD 21. SIGNATURE OF FUNERAL examiner 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home Julas 108 Williams St Berlin, MD the medical 23. PART I. Enter the diseases, or complications net ceused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shook, or heart fellure. List only one Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition_ resulting in death) traumatic event, AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE IDDM shows any 1 TES 2 NO DF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 6 Reeldence 6 Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, Netural 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED t YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, 90 ED 6 Could not be 4 Homicide 28 determined COMPLET 1 X CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. (Check only one) ation, in my opinion, death occured at the time, date and place, and due to the ceuse(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE D47528 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27).

560 Riverside Dr. StaA

M.D.

32. REGISTRAR'S SIGNATURE

21801



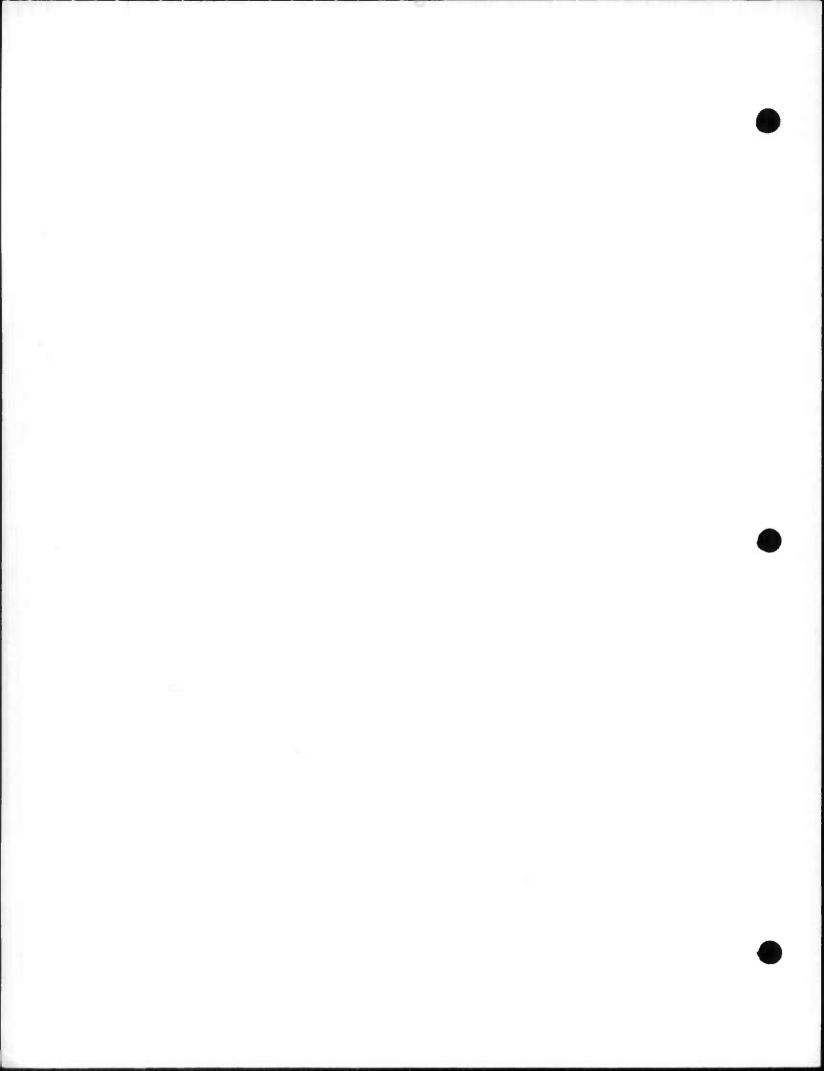
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL HYGIEN | | |
|---------------|------------------------------------------------------------|-------------------------------------------|-----------------------------------|---------------------------|-----------------------------------------|----------------------------|-----------------|--------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | RUTH M. BISHOP | | | | | Aug 27, | 1995 | YEAR 11:55 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | - 1 | B. BIRTHPLACE (State or Foreign |
| | 212-74-4512 9e. FACILITY NAME (If not institution, give a | 1 □ M 2 💢 F 87 | YRS. | MONTHS DAYS | HOURS MIN. | Sep 27, 1 | V | Country) WV |
| Œ | 12520 GOLDENS AV | | | CUMBERI | DR LOCATION OF D | EATH | | ry of death EGANY |
| DIRECTOR | RESIDENCE OF DECEDENT | THOE SE | | COLIDERO | | | | 30212 |
| I W | 10e. STATE 10b. COUNT | Υ | 10c. CIT | Y, TOWN OR LOCAT | TION | | | 10d. INSIDE CITY |
| | MD Alle | gany | Cur | mberland | | | | 1 YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | CV 53 | | 101 | . ZIP CODE | | | EN OF WHAT COUNTRY? |
| ij | 12520 Goldens Av | | | 2 | 21502 | | USA | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1 YES | N U.S. ARMED | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specify Yes | or No- 1 | 4. RACE — American Indian, Black, White, etc. |
| BY | 3 😾 Widowed 4 🗌 Divorced | IF YES, GIVE WAR OR D | ATES | | 2 X NO Speci | | | Specify: |
| | 15. DECEDENT'S EDU | CATION | 16e DECEDENT'S | USUAL OCCUPATION | 2N | 16b. KIND OF BU | 1 | white |
| ETED | (Specify only highest grade Elementary/Secondary (0-12) | Coffege (1-4 or 5+) | (Give kind of v | work done during mo | st of working | 166. KIND OF BU | SINESS/INDU | SIRY |
| 길 | 12 | Conege (1-4 of 5+) | Homema | ker | | Own H | ome | -07 |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | 1101104104 | 3102 | 18. MOTHER'S NA | AME (First, Middle, Maiden | | |
| ш | Lemuel Buckle | V | | | Libby | (Clouwer) | | 1,00 |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | | Route Number, City or Tow | n, State, Zip C | (ode) |
| F | Donna Shipley | | Route | 2 Box 14 | 2C; Key | ser. WV 20 | 5726 | |
| | 20a. METHOD OF DISPOSITION 1 N Burlel 2 Cremation 3 Rem | | PLACE AND DATE | OF DISPOSITION (Na | | | | ty or Town, State |
| | 4 Donation 5 Other (Specify) | M | netery, cremetory or of the Tabor | Cemeter | | 08/30 01 | dtown, | , MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | // | | ADDRESS OF FA | | | |
| | James + | X/Can | nll. | Scarp | errand M | meral Home MD 21502 | | |
| | 23. PART / Enter the diseases, or other tellum | complications that course | the death. Do n | ot enter the mo | de of dying, suc | th as cardiac or reapi | ratory arres | nt, Approximate |
| | shock, or heert failure. IMMEDIATE CAUSE (Final | List only one ceuse on e | ach line. | | | | 11/1-11/11 | interval Between Onset and Death |
| | disease or condition resulting in death) | a. PULMO DUE TO (OR AS A | NARM | EM | BOLIS | M | | / DAV |
| | rosaning in double, | DUE TO (OR AS A | CONSEQUENCE OF | T): | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 1. |
| Z | Sequentially list conditions, | b | | | | | | |
| Ĕ | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF | ገ : | | | | |
| 길 | CAUSE (Disease or injury | COUE TO (OR AS A | CONSEQUENCE OF | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSCOUENCE OF | ·): | | | | |
| S | | d | | | | | | |
| AL | PART II. Other significant condition | s contributing to deeth b | ut not reaulting i | n the underlying | ceuse given in | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDIC | | | | | | 1 🗆 YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| M | | | | | | | C | 1 TYES 2 NO |
| PHYSICIAN: M | DID TOBACCO USE CONTI | RIBUTE TO CAUSE O | F DEATH YE | S INO | UNCERTAIL | N 🗆 | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEAT | H (Check only one) OTHER: | | | | |
| YSI | 1 TYES 2 NO | 1 Inpatient 2 I ER/Outp | atient 3 🗆 DOA | | 5 X Residence | 6 C Other (Specify) | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIMI INJI | URY WO | RK? | 28d. DESCRIBE HOW I | NJURY OCCU | RED |
| B | 2 Accident Investigation | 20- 51 405 05 10 10 10 | | | ES 2 NO | | | |
| 8 | 3 Suicide 6 Could not be 4 Homicide determined | | | | | | | |
| COMPLETED | 29e. CERTIFIER | | | | | | | |
| MP | (Check only CERTIFYING PHYSI | CIAN: To the best of my knowl | | | | | | |
| 8 | | | and/or investigation | n, in my opinion, de | eath occured at the | time, date and place, en | | cause(s) and menner ee stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Di in | 20 | | 29c. LICENSE NUI D25406 | MBER | 29d. DATE 8 | 19.28,1995 |
| 5 | Mull all | Jum VV | リ | | DZ3400 | | Au | 4.00,1115 |
| | Dr. William Lamm | ; 47 Virgini | ath (ITEM 27) (Type, a Avenue | ; Cumber | land, M | 21502 | | |
| | 31. DATE FILED (Month, Day, Year) | 32 AGGISTRAR'S SIGN | ATURE A | | | | | |
| | AUG 2 8 1995 | JULY DRUME | x-handall | | | | | |



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| | HOSPITAL |

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 1995 LEO JOSEPH **BREHM** August 18 16:55 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. HOURS YRS. 216-30-2041 Apr 15, 61 1934 MD Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Memorial Hospital Medical Center DIRECTOR Cumberland Allegany RESIDENCE OF DECEDENT tob. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Allegany Cumberland 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13515 Poppy Street USA use as the burial-transit 21502 attending physician. t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE --- American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: ВУ 3 Widowed 4 Divorced white 1956-1957 COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only high the hospital or Elementary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) Cumberland Monument Co. Monument Worker 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) 76 retained by Josephine (Lisanti) BE Melvin Brehm notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 13515 Poppy Street; Cumberland, MD Madelvn H. Brehm P 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Mary's Cemetery 08/21 Cumberland, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 ag. medical 23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List pnly pne cause pn each line. filled in by Approximata 6 IMMEDIATE CAUSE (Final Onset and Death the cremation. disease or condition resulting in death) Non-small Cell Carcinoma of Lung completely 6 Months event. DUE TO (OR AS A CONSEQUENCE OF): attending physician and con ental Hygiene prior to burial, Hypercalcemia traumatic 4 Weeks CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Mets to Liver 6 Months CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 the atten Mental PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL this certificate has been signed by with the State Dept. of Health and AMILABLE PRIOR TO COMPLETION DF CAUSE any 1 TYES 2 X NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [NO [PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 1 Inpatient 2 ER/Outpatient 3 DOA 1 TES 2 NO OTHER: 4 - Nurs ng Nome 6 - Residence 6 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 26d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural t YES 2 NO DIRECTOR: After the hours after death BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 8 Could not be COMPLETED 28 4 Homicide Item 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL Within 72 F 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
Se filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE August 229 D 23371

<u> Johnson Heights Medical Blgd.</u> Cumberland MD

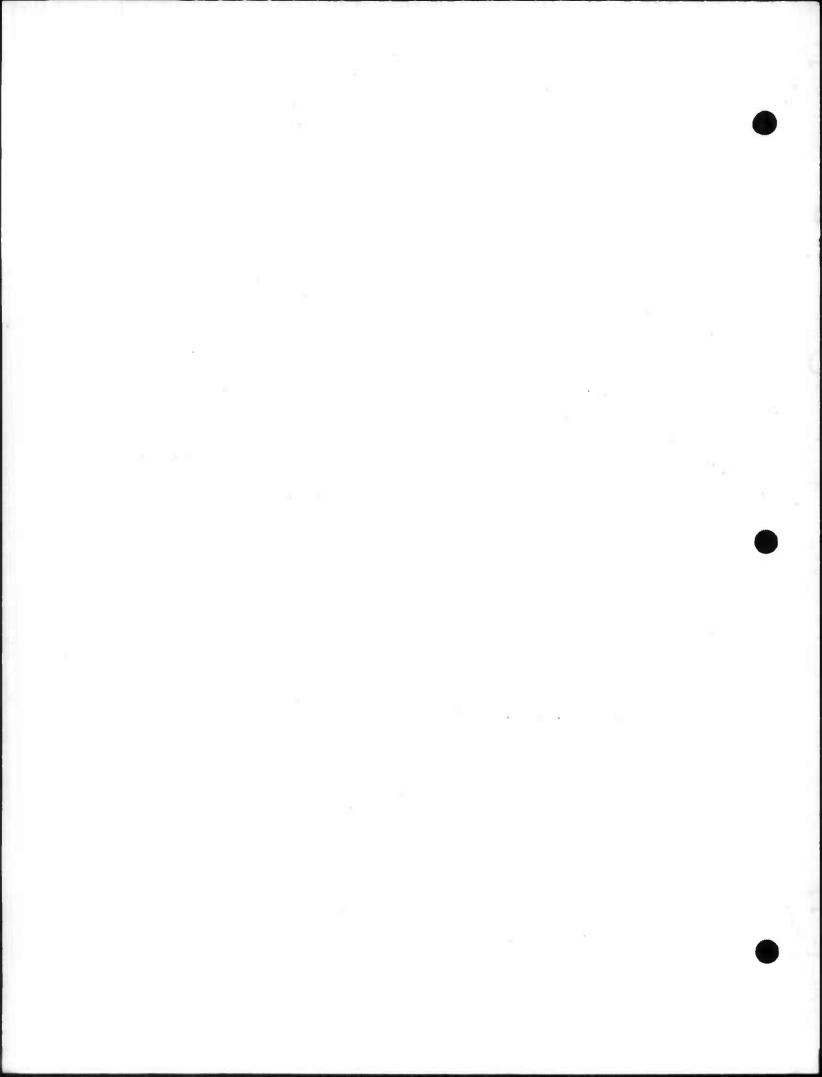
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 AEGISTHAR'S SIGNATURE

Oamar Zaman M.D

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

21502



retained by the hospital or attending physician. 5 should be detached for use as the burial-transit **MORE, MARYLAND 21215-0020** Page 6 may be

director,

huneral

ANDROW NOWAKOWSKI

32. HEGISTRAME SIGNATURE RANGALL.

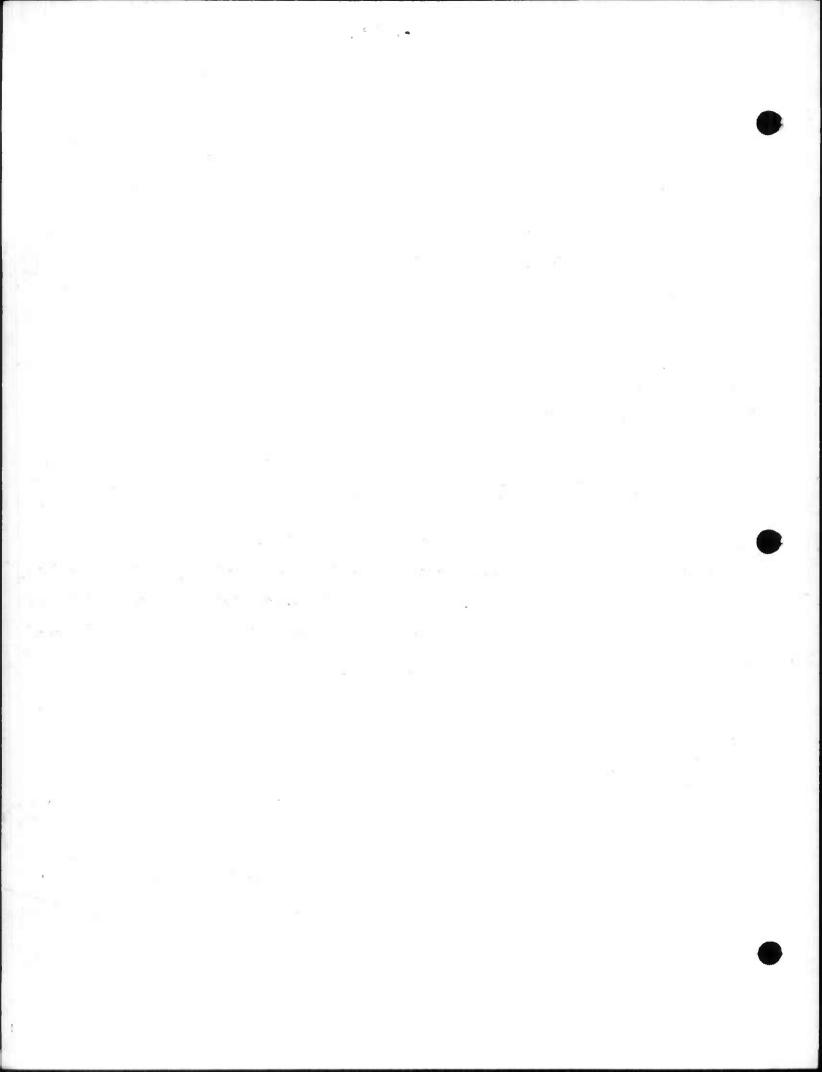
Pages 1, 2, 3 should

permit, I

| BALI | leath. | funera | xami |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| â | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examin |
| _ | hours | ed in | med |
| | T | ation. | the |
| 90 | 1 with | mplete | went, |
| 20 | ecuted | nd co burial | atic e |
| DIVISION OF VITAL RECORDS, P.O. BOX 68/60 | De ex | cian a | Manu |
| Ď. | ificate | physis and pr | her t |
| 7. 5. | th cert | ending Hygi | Or 01 |
| ń | e dea | the att Memta | jury, |
| Ĭ | that th | by by | my le |
| ב | quires | Healt | DWS 3 |
| Ī | W rec | Deer of | 3 sh |
| A | e a | has | n 23 |
| | N: T | State | Her |
| L | SICIA | certi | 1 0 |
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| 5 | DING | Afte | E |
| 0 | TEN | after after | 28 |
| 5 | OR A | DIREC | Hem |
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| | HOSP | FUNE | TANT |
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| | 2 | 23 | Ξ |
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 2!15 ruggmar 108 28 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 9/25/1916 IF UNDER I YEAR BIRTHPLACE (State or Foreig Country) IF UNDER 24 HRS. DAYS HOURS 1 - M 2 - F 218-01-5109 78 Maryland 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford Memorial Hospital Harford Havre de Grace RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Churchville 1 X YES 2 NO 10a. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 109 Glenville Road 21028 USA 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 3/5 NO Specify: 14. RACE - American Indien, Black, White, etc. Never Merried 2 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 10 Taxi/Cab Driver Transportation 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) न Richard Bruggman Effie May Greenland BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Elender G. Odom 109 Glenville Rd., Churchville, MD 21028 99 20s. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Burisi 2 Cremation 3 Removal from State
4 Donalion 5 Other (Specify) Holy Trinity Episcopal Cemt 8/30 Churchville, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Tarring-Cargo Funeral Home, P Aberdeen, Maryland 21001-3399 rannu medical 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heart failure. List only one cause on each line. ahock, or interval Betwee IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ CONGESTIVE HEART FAILURE YEAR reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) HEART 5 YEHRS ISCHEMIC DISTASE CERTIFICATION Sequentielly ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury YEHRS A LAGETES MELLIMUS INSULIN -DEPENDENT or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in deeth) LAST MULTINFARCT DEMENTIA YEARS shows any injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL SEPSIS, PSEUDOMONAS URINARY 1 TYES 2 NO OF DEATH? INFECTION, ASPIRATION PNEUMONIA 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA reing Home 5 - Residence 8 - Other (Specify) marked, or 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 8 Could not be COMPLETED 4 Homicide 28 Hem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D0+096 Andrew Nowahowski ►AUGUST 29,1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MD, 125 N. MAIN ST. BEZATR, MD21014



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | E | | |
|------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------|---------------------|---------------------|---------------------------------------------------|-----------------------------------------|-------------------------------------------|--|
| | t. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF OEATH | |
| | MARY | FILEN | CRISLIP | | | August 20 | | 11:07 PM | |
| | 4. SOCIAL SECURITY NUMBER | | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign | |
| | 200-28-3713 | | 7.5 YRS. | NTHE DAYS | | (Month, Day, Year) March 23.1 | | nsvlvania | |
| œ | ••. FACILITY NAME (If not Institution, give str Memorial Hospi | , | 96 | | location of DE | | 9c. COUNTY OF | | |
| DIRECTOR | RESIDENCE OF DECEMENT | | | Odmber | Talle, In | aryrand | Alle | garry | |
| E | 10a. STATE 10b. COUNTY | | 10c. CITY, TO | OWN OR LOCATI | ON | | | 10d. INSIDE CITY LIMITS? | |
| | | dford | Н | yndman | | | | t 💢 YES 2 🗌 NO | |
| FUNERAL | toe. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | |
| | PO.Box 202 Church | | | | 15545 | | | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | | If yes, spe | city Cuben, Mexices | IC ORIGIN? (Specity Yes n, Puerto Ricen, atc.) | or No— 14. RAC Blac | CE — American Indian, ck, White, etc. | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ATESY. | 1 TYES | 2 NO Specify | | Spe | White | |
| COMPLETED | 15. OECEDENT'S EDUC (Specify only highest grade of | | 16e. DECEDENT'S USI | | N: | 16b. KIND OF BUS | SINESS/INDUSTRY | WILLE | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use re | tired.) | t or working | | | | |
| MP | 8 | | Homemak | er | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAI | ME (First, Middle, Melden | Surneme) | | |
| 8 | Charles BOH 190. INFORMANT'S NAME (Type/Print) | N | | | Tillie | | oyer) BO | HN | |
| 2 | PERSONNER HEREST WORLD | | 19b. MAILING AD | | | Noute Number, City or Tow. | | | |
| | JoAnn CRISLIP | 200 | . PLACE AND DATE OF D | | | oad, LaVal | e. Maryl | | |
| | 1 & Buriel 2 Cremation 3 Remo | rval from State cam | netery, crematory or other | place) | ne or | L | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | arger Ceme | | O AODRESS OF FAC | 8/23/95 B | uffalo M | ills, Pa | |
| | | | | Harve | v H. Ze | igler Fune | ral Home | , P.O. Box | |
| | HARVEY H. ZEI | | 4.45-4-45-80-4 | 636 | Hyndman | Pa. 155 | 45 | | |
| | 23. PART I. Enter the diseasea, or co shock, or heart fellure. L | | | enter the mod | le of dying, such | as cardiac or respi | ratory srrest, | Approximate interval Between | |
| | iMMEDIATE CAUSE (Finei disease or condition | Onset and Death | | | | | | | |
| H | resulting in death) | a. Ventricular Arrythmias 24 hours | | | | | | | |
| _ | | - Myocardial Infarction 24 hours | | | | | | | |
| 힐 | Sequentielly list conditions, if any, leading to immediate | | CONSEQUENCE OF): | | | | | 24 1100115 | |
| S | CAUSE (Disease or injury | Coronary An | rtery Dise | ase | | | | Unknown | |
| | that initiated eventa resulting in death) LAST | | | | | | | | |
| CERTIFICATION | d | Ischaemic (| Cardiomyop | athy | | | | Unknown | |
| AL 0 | PART II. Other eignificent conditions | contributing to deeth b | ut not resulting in t | he underlying | ceuse given in | Part I. 24a. WAS AN | | b. WERE AUTOPSY FINDINGS | |
| Š | Diabetes, Hypot | hyroidism, (| Osteoporos | is, | | 1 YES 2 | | AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| Ä | Diabetic Neurop | | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | OF DEATH? | |
| ž | DID TOBACCO USE C | ONTRIBUTE TO | CAUSE OF D | EATH YE | S NO | X | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOCOITAL | | | ACE OF OEATH (Chi | ck only one) | | | |
| YSi | 1 TYES 2 NO | HOSPITAL: | entient 3 DOA 4 | THER: Nursing Home | 5 - Residence | 8 Other (Specify) | | | |
| 표 | 27. MANNER OF OEATH 1 Natural 5 Pending | 28a. OATE OF INJURY (Month, Day, Year) | 28b. TIME O | WOI | IK? | 28d. DESCRIBE HOW I | NJURY OCCUREO | | |
| B | 2 Accident Investigation | | | | ES 2 NO | | | | |
| | 3 Suicide 8 Could not be 4 Homicide datermined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, term, stree ://y) | et, factory, office | | 281. LOCATION (Street e City or Town, State) | and Number or Aural | Route Number, | |
| 9 | 29e. CERTIFIER | | | | -1944 | | | | |
| COMPLETED | (Check only | CIAN: To the best of my known a: On the beele of examination | | | | | | (n) and manner stated | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | ориноп, оп | | | | | |
| 띪 | Huma Rushi | MA | | | 29c. LICENSE NUM | | | O (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) /Time Pri | 76) | D 463 | 40 | Augus | t 22 1995 | |
| | Dr. Huma Shakil, J | | | | . Cumber | rland. MD | 21502 | | |
| 3 | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIGN | ATURE | - Diug | , Juilibe. | Land, III | ter de al V bes | | |
| 1 | DIIC 2 3 1995 Ju | ha Davelson-Rano | lall | | | | | | |
| | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

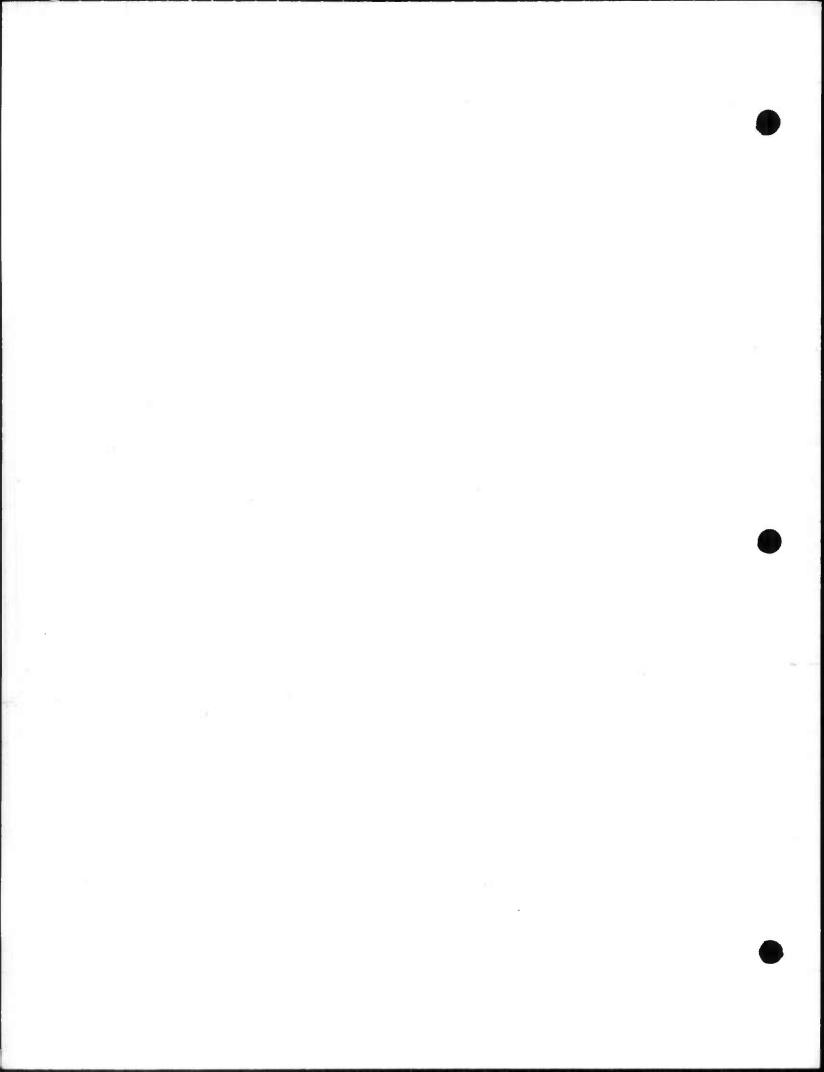
IMPORTANT: If Item 28 Is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

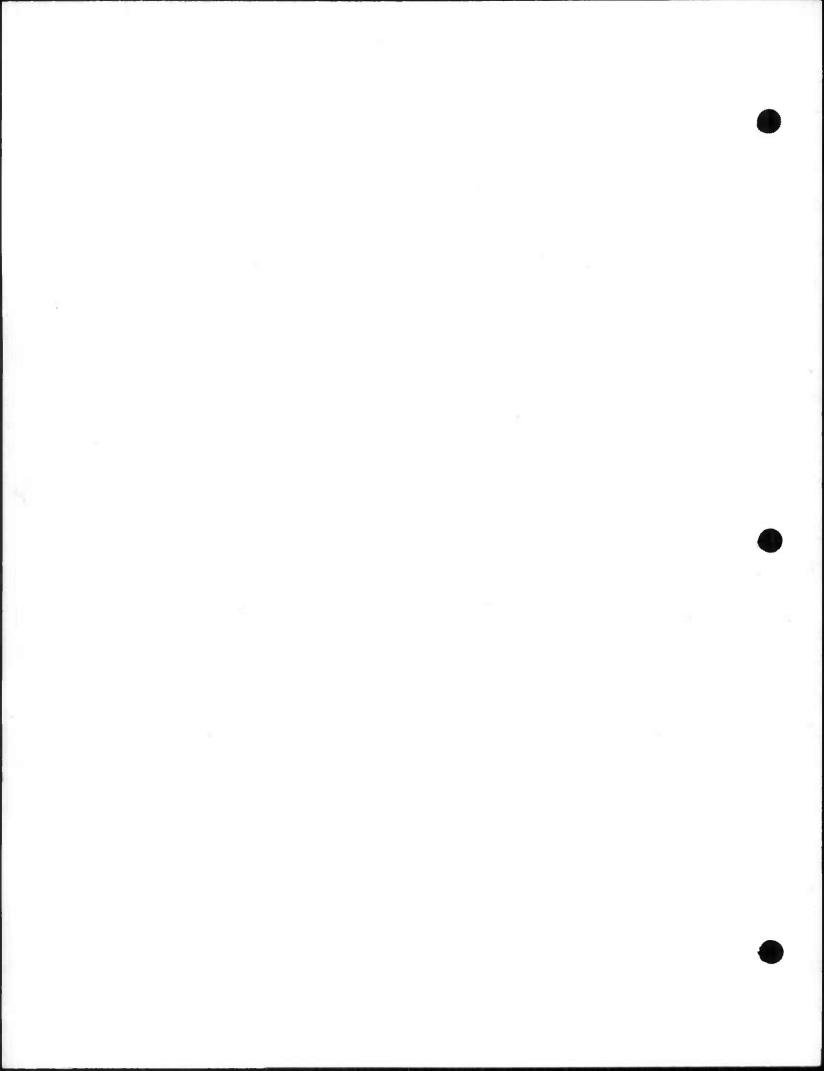
| - 9 | 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------|-------------------|-----------------------------|---------------------------|-------------------------------------------------------|---------------|-----------|------------------------|--------------------------|------------|-------------------|------------------------------------|
| LEVI ELLSWORTH CRABTREE AUGUST 19 1995 1:20 | | | | | | | | 1:20 A M | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SE | X | 8. AGE (In yrs. I | est birthday) | | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | BIRTH | | S. BIRTH | IPLACE (State or Foreign |
| - 1 | 215-20-6211 | 17/2 | M.2 🗀 F | 82 | YRS. | MONTHS | DAYE | HOURS | MIN. | | O, 19 | 12 | Country | γ) |
| - 7 | 9a. FACILITY NAME (If not institution | | | UL | | 9b. CITY | r, TOWN (| OR LOCATI | ON OF DE | | U, 1. | _ | | MD |
| 96. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 106. STATE 106. STATE 106. CITY, TOWN OR LOCATION 106. INSIDE CLIMITS? 107. INSIDE CLIMITS? | | | | | | | | | | | | | | |
| 딦 | RESIDENCE OF DECEDE | COUNTY | | | 10c CIT | Y, TOWN | OBLOCA | TATON. | | | | 100000 | 1 | |
| E | | | | | | | | ION | | | | | - 1 | 10d. INSIDE CITY LIMITS? |
| | MD A | 11egan | Υ | | 1 010 | ltown | | . ZIP CODI | | | | T | | 1 YES 2 NO |
| A | | | | | | | - | | | | | | | WHAT COUNTRY? |
| FUNERAL | Route 1 Box 9 | | #6 DECEDEN | T EVER IN U.S. A | DATES | | | <u> 1555</u> | | | | USA | | |
| | 1 Never Married 2 Marrie | ed F | ORCES? 1 | YES 2 | NO | | If yes, sp | ecify Cuba | n, Mexica | IIC ORIGIN? | (Specify Ye an, etc.) | a or No | 14. RACE Black | American Indian, t, White, etc. |
| BY | 3 Wildowed 4 Divorced | II. | TES, GIVE W | AR OR DATES | | | 1 TYES | SX NO | Specify | y: | | | Spech | |
| | 15. DECEDENT | T'S EDUCATION | Ü | 16a, D | ECEDENT'S | USUAL O | CCUPATIO | ON | | 16b, K | IND OF BU | SINESS/INI | | hite |
| COMPLETED | (Specify only highs Elementary/Secondary (6-12) | | red) ege (1-4 or 5 + | | Give kind of vie. Do NOT us | work done se retired.) | during mo | at of working | g | | -1.11 | | | |
| 립 | 12 | | -ge (1-4 01 5 4 | | mer/o | oner | a+or | | | | rcha | For | | |
| 0 | 17. FATHER'S NAME (First, Middle, I | Last) | | I OV | MICLA | JUCIL | ator | | IER'S NA | ME (First, Mic | | | | |
| | William C. | Crahtr | -00 | | | | | | | Jane | | | | |
| BE (| 19a. INFORMANT'S NAME (Type/Pri | | | 1 | 9b. MAILING | ADDRES | S (Street e | | | Route Number | | | Code) | |
| 2 | Dora E Crabt | roo | | | oute ' | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION | | | 20b. PLACE | ANDDATE | OF DISPOS | SITION (Na | | JIFOW | DATE | 215 20c. LC | CATION — | City or Ton | wn. Stata |
| | Burlet 2 Cremetion 3 4 Donation 8 Other (Speci | Removal fro | om State | | nematory or or | | | . 7 | | 08/22 | | | | |
| | 21. SIGNATURE OF FUNERAL SER | VICE LICENSEE | , | | | | | D ADDRES | SS OF FA | | 31 | | 7 | |
| | 1 Canal | 70 | Man | | 11. | S | carp | elli | Fune | eral 1 | Home | | | |
| | 23. PART . Enter the disease | es or compli | cations that | Court of the o | anth Do | | umbe | rland | 1. M | D 21. | 502 | | | Approximate |
| FICATION | disease or condition resulting in death) s. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): 2 DAYS | | | | | | Onset and Death | | | | | | | |
| ERTI | that initiated evente resulting in death) LAST | d | | OR AS A CONSE | | | | | | | | | | |
| MEDICAL CERTIFICATION | PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? | | | | | | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| | DID TOBACCO USE C | ONTRIBLIT | TE TO CAL | ISE OF DE | ATH VE | сПі | NO IP | LING | EDTAIN | | | | | 1 TYES 2 DE NO |
| M | 25. WAS CASE REFERRED TO MED | | IL TO CA | | CE OF DEAT | | | OIAC | EKIMI | 101 | | | - 1 | Va |
| SIC | EXAMINER? 1 YES 2 NO | | PITAL: | FR/Outpatient | 3 🗆 DOA | OTHE | | | | | | | | |
| PHYSICIAN: | 1 YES 2 NO 1 DS Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 8 Residence 8 Other (Specify) 27. MANNER OF DEATH 286. DATE OF INJURY 286. TIME OF 28c. INJURY AT 286. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | | |
| | 1 Natural 5 Pendin | | (Month, Da | y, Year) | INJ | URY | | RK? 'ES 2 | NO | | | | | |
| ED BY | 2 Accident Investig | not be | ton, PLACE OF building, a | INJURY — At h | ome, tarm, a | treet, fact | | | | 281, LOCATI City or | ON (Street li | and Number | or Rural R | oute Number, |
| Ē, | | | | | | | | | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL E | | | | | | | | | | | | | and manner we stated. |
| | 196. SIGNATURE AND TITLE OF CE | | | | | | | | | | | | | |
| ᆲ | (- F | h- | | V | W | | | 29c. LICE | | IDEN | | | | (Month Park 1997) |
| 유 | 30. NAME AND ADDRESS OF PURS | ON WHO COMP | PLETED CAUS | E OF DEATH (ITE | M 27) (Type, | Print) | | D 12 | 1/19 | | | Al | JGUST | |
| 1 | GUY FISCUS M.D., MEMORIAL HOSPITAL MEDICAL BLDG, CUMBERLAND, MD 21502 | | | | | | | | | | | | | |
| | | | ORIAL | HOSPITA | L MED | ICAI | BLI | OG, C | UMBI | ERLANI | , MD | 215 | 02 | |
| | GUY FISCUS M.D. 31. DATE FILED (Month, Day, Year) AII G 23 | 3 | 2. REGISTRAF | HOSPITA | _ | ICAL | BLI | OG, C | UMBI | ERLANI | , MD | 215 | 502 | |



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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Nem 28 is marked, or filem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | | |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------|----------------|-------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------|------------|---------------------------------------------|-------------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | OSITIVIDATE OF DEATH | | | | 2. DATE OF DEATH 1. TIME OF DEATH | | | | | | | |
| | HAZEL | | COWGILL | | | | | | | 1995 | 19:30 M | | | |
| | 4. SOCIAL SECURITY NUMBER | 6. SEX 6. | | | | IF UNDER 24 HRS. HOURS MIN. | N. (Month, Day, Year) | | | 8. BIRTHPLACE (State or Foreign Country) | | | | |
| BY FUNERAL DIRECTOR | 213-40-3880 Se. FACILITY NAME (If not institution, give atn | C | 2 X F 82 YMS. | | | | OCT, 3/1 | | | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | |
| | MENODE IN COLUMN | | | | | TY, TOWN OR LOCATION OF DEATH BC. COUNTY (| | | | | 100 | | | |
| | RESIDENCE OF DECEDENT | E OF DECEDENT | | | | | CUMBERLAND | | | | ALLEGANY | | | |
| | | | | | y, town or location | | | | | | 10d. INSIDE CITY LIMITS? | | | |
| | 10e. STREET AND NUMBER | SEIGEN | | 101. ZIP CODE | | | | | 10a CITI | ZEN OF W | 1 YES 2 NO | | | |
| | 8 Celeste | Drive | | | | | | USK | | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married | VER IN U.S. ARMED 13. WAS DECENDENT OF HI YES 2 NO If yes, specify Cuben, M | | | ENDENT OF HISPA | PANIC ORIGIN? (Specify Yes or No — 14 xican, Puerto Rican, etc.) | | | | - American Indian, White, etc. | | | | |
| | 3 Widowed 4 Divorced | IF YES, OIVE WAR | | | | | | | | | White | | | |
| E | 15, DECEDENT'S EDUCA (Specify only highest grade of | ATION | 18a. DECEDENT'S USUAL OCCUPATION | | | | 16 | b. KIND OF BU | SINESS/IND | USTRY | WHITE | | | |
| 9 | Elementary/Secondary (0-12) | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | 100 | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Leat) | | | Housewife | | | | Н | 5 | | | | | |
| 2 | Derbin Hocken berny | | | | | 18. MOTHER'S N | | | n Sumeme) | | | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | ALLINO ADD | RESS (Street a | | | | | 21502 | | | | | |
| 2 | Mayward Cowgill 707 Badford St. Cumberland Mid | | | | | | | | | | md | | | |
| | 20e, METHOD OF DISPOSITION 1 D Buriel 2 Cremation 3 Remove | val from State | 20b. PLACE AND comptery, crome | | | me of d | DAT | E 20c. LC | CATION - | City or Tov | on, State | | | |
| | 4 Donation 8 Other (Specify) | NREF | SUNS | 07 N | 10M2 | Park E | 3 | S CU | Mpo | rlan | d, Morylow | | | |
| | · Ernest | | 1 | | | are-Stei | n.In | c. 230 | Ralt | imor | e Avenue | | | |
| | | / | / | Do cot c | Cumb | erland, | Md. | 21502 | Duit | | e Avenue | | | |
| | enock, or heart fellure. Li | ist Dnly Dna cause t | e on each line. | | | | | | | Approximete interval Between | | | | |
| | iMMEDIATE CAUSE (Fine) disease or condition resulting in daeth) | CEREBROV | VASCULAR ACCIDENT | | | | | | | | Onset and Death 2 days | | | |
| | a. | | (DR AS A CONSEQUENCE OF): | | | | | | | 2 days | | | | |
| NO | Sequentielly list conditions, 6. | HYPERTEN | ENSION OF AS A CONSEDUENCE OF: | | | | | | | | 15 years | | | |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING | PNEUMONIA | | | | | | | | | 3 days | | | |
| Ĕ | that initieted events | | | | | | | Jadys | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | 171 | | | | | | | |
| AL C | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY FINDINGS | | | | | | | | | | | | | |
| 20 | PÉRFORMED? 1 □ YES 2 □ NO | | | | | | | | | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHS | | | |
| MEDIC | 1 YES 2 NO | | | | | | | | | | | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRI | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | | |
| SICI | EXAMINER? | EXAMINER? HOSPITAL: | | | | | | | | | | | | |
| ¥ | 27. MANNER OF DEATH | 8b. TIME OF | 28c. INJI | IRY AT | 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| BY | 1- Natural 5 Pending (Month, Day, Year) 2 Accident Suicide 6 Could not be determined determined | | | | INJURY WORK? 1 YES 2 No 1e, farm, street, factory, office | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| _ | | | | | | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my knewledge, death occurred at the time, data and place, and due to the cause(a) and manner se stated. | | | | | | | | | | | | | |
| MP | (Check only | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| BE | 1.Tul | tota | | | | D 36766 | | | | AUGUST 21 1995 | | | | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO | שאסוסנ ע | 66 AUGUST 21, 1993 | | | | | | | | | | | |
| | DR. VIK POONAI, 95 | | CK STRE | ET, C | UMBERL | AND, MD | 2 | 1502 | | | | | | |
| 0 | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | BIGNATURE | 1.11 | | | | | | | | | | |
| | дис 2 3 199 ! | DI Julia OU | | vay | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | HEGISTHAR | | | :HIIF | ICALE | = OF | DEA | I H | | REG. NO | | | | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------|-----------------------------------------|-----------------------------------------------|------------------------------------------|---------------------------------------------------------|-----------------|-------------------------------------------------------------|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) LOUIS CONNOR | | | | | | | | | 2. DATE OF DEATH MONTH DAY AUG 19 | | | 3. TIME OF DEATH | |
| | | | | | | | | | | | | 1995 11:58 M | | |
| 1 | 214-16-2380 | 1 📉 M 2 🗌 F | in the first test of | | S. WONTHS DAY | | HOURS MIN | | (Month, | 7. DATE OF BIRTH (Month, Day, Year) June 17, 1917 | | e. BIRTNPLACE (State or Foreign Country) Pennsylvania | | |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY | , TOWN C | OR LOCATI | ON OF DE | | | | TY OF DEATH | | |
| DIRECTOR | Washington Adventist Hospital | | | | Takoma Park | | | | | Montgomery | | | | |
| 8 | 10a. STATE 10b. COUNTY | | | 10c, CIT | Y. TOWN C | DR LOCAT | ION | | | | | 104 | INSIDE CITY | |
| PIR | Maryland Allegany | | | | Cumberland | | | | | | | | LIMITS? | |
| ¥ I | 10e, STREET AND NUMBER | | | | 100 00 | | | . ZIP CODE | | | 10g. CITIZ | EN OF WHAT | COUNTRY? | |
| FUNERAL | 507 Maryland Avenue | | | | | | R802 21502 | | | 2 | 1 | U.S.A. | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF | | | | 13. | WAS DEC | ENDENT OF HISPANIC ORIGIN? (Specify Yes | | | or No- | 14. RACE / | American Indian, | | |
| BY | 1 Never Merried 2 ☐ Merried 3 ☐ Wildowed 4 ☐ Divorced FORCES? 1 ☐ YES 2 ☐ IF YES, GIVE WAR OR DATES W . W . ☐ | | | Ю | If yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 YES 2 NO Specify: | | | | | Black, Wh Specify: | vhite | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 168. KIMD OF BUSINESS (MADDISTRY | | | | | | | | | | | | | |
| <u> </u> | (Specify only highest grade completed) [Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) Insert secondary (0-12) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) | | | (Give kind of work done during most of working fe. Do NOT use retired.) | | | | ng | | | | | | |
| 릴 | 12 4 | | | Teacher | | | | | Public Sch | | | | 6 | |
| 0 | 17. FATHER'S NAME (First, Middle, Last) | | | 10. MC | | | 18. MOTI | MOTHER'S NAME (First, Middle, Maiden Surname) | | | | SCHOOLS | | |
| | Walter E. Connor Sr. | | | | | | | | ie Da | | | | | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | 7 101 6 | 198 | MAILING | ADDRESS | /Street a | | | | | n, State, Zip C | 2.4. | | |
| 2 | Dorothy Shaffer | | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION | | | | | | | 18 CI | | | Md. 2 | | | |
| | 1 Burial 2 Cremetion 3 Remo | oval from State | cemetery, crea | natory or of | D DATE OF DISPOSITION (Name of altory or other place) | | | | DATE 20c. LOCATION — City or Town, State | | | | | |
| | | | | | | | | | | .23,95 Eckhart, Maryland | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Durst Funeral Home | | | | | | | ne | | |
| | John K. | | 57 Frost Avenue Frostburg, Md. 21532 | | | | | | | | 32 | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | interval Between IMMEDIATE CAUSE (Finel Onset and Death | | | | | | | | | | Onset and Death | | | |
| 1 | disease or condition | | | | | | | | 70 11 | | | | | |
| ļ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 14 long | | | |
| z | IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF: Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF: | | | | | | | | | 20 V | | | | |
| ᅙᆘ | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | no pesant | | | |
| 8 I | | | | | | | | | | | | | | |
| Ē | | | | | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | | | |
| | PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY FINDINGS | | | | | | | | | | | | | |
| EDICAL | PART II. Other aignificant conditions | reaulting in the underlying ceuse give | | | given in | Part i. | 24a. WAS AN PERFOR | | | E AUTOPSY FINDINGS | | | | |
| 음 | | | | | | | 1 _ YES 2 W NO | | | COMPLETION OF CAUSE OF DEATH? | | | | |
| ME | | | | | | | | | YES 2 NO | | | | | |
| | DID TOBACCO USE CONTR | IBUTE TO CAL | JSE OF DEAT | TH YE | S 🗆 N | 10 K | UNC | ERTAIN | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) | | | | | | | | | | | | | |
| 3 | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Dispitlent 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) | | | | | | | | | | | | | |
| ≟ ∥ | 27. MANNED OF DEATH | 28e. DATE OF II (Month, Day | | | | | | 28d. DEŞCRIBE NOW INJURY OCCURED | | | | | | |
| | 1 Natural 5 Pending | ILNI | JRY M | | WORK? | | 200. 0200 | THE HOW I | WORL OCCO | HED | | | | |
| à l | 2 Accident Investigation | | | | | | YES 2 NO | | | | | | | |
| 요 | 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At hombuliding, atc. (Specify) | | | | ireet, mete | эгу, отне | • | | | Town, State) | nd Number or | Number or Rural Route Number, | | |
| COMPLET | Ale CENTRIES | | | | | | | | | | | | | |
| 린 | 29a. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated, | | | | | | | | | | | | | |
| ō I | one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | |
| 0 | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c, LICENSE NO | | | | | | | E SIGNED (Marrit, Day, Year) | | |
| ∞ ∥ | Allena | | | | 7) A | | | 18062 | | | > @ | 2/10/2 | | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO | 27) (%me | - 21883 5/1971 | | | | | 3 | | | | | | |
| | AITTUA | (T) es -= ! | 174 | | | , , | lan | 1 | . 1 . | 1 | 1805 | - 2 | 20009 | |
| | 31. DATE FILED (Month, Day, Year) | 1 62 property | 110 | 6/ | VRO | N /1 | ny | P.5H | IRRI | TVE. C | 115 | HING | ron D.c. | |
| | Alie 2 2 1995 | Ala Aban | SIGNATURE | 1 | | | | | | | | | | |
| | Mili: # 5 1999 | 7 | an wandal | 6 | | | | | | | | | | |
| | - | | | | | | | | | | | | DNMN-16 Rev 1/89 | |

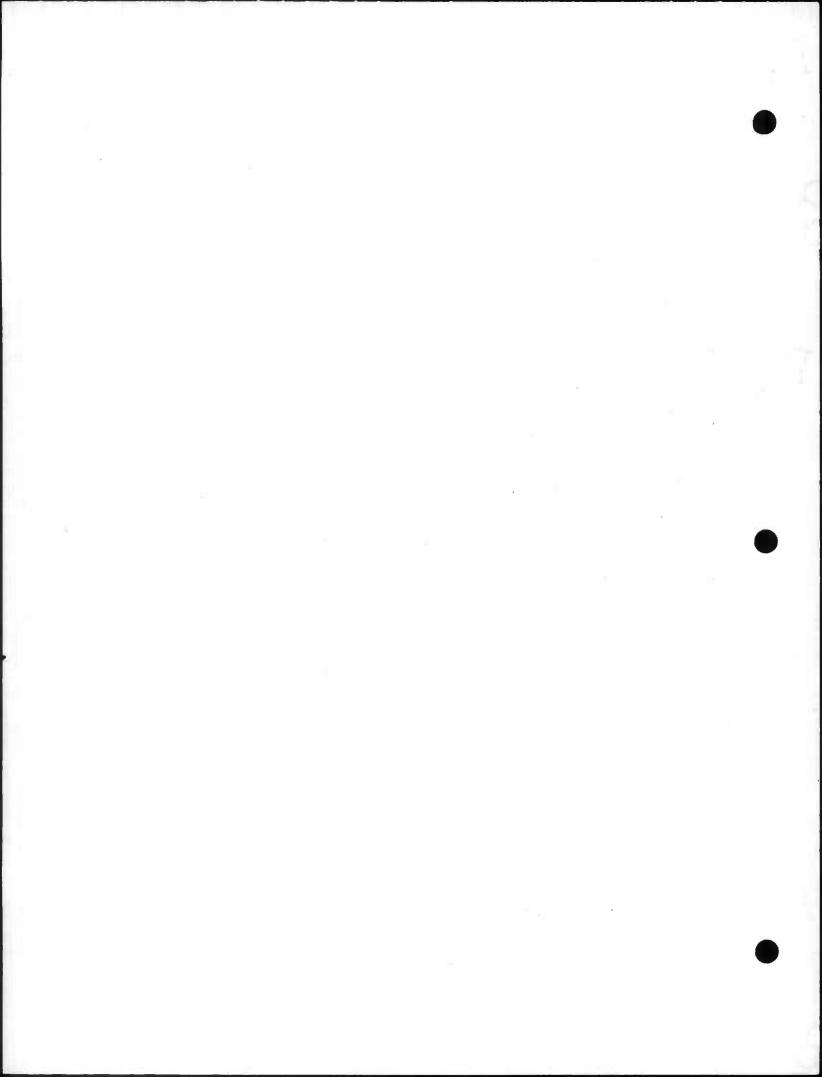
0615140 CONNOR. 8-15-95 M/R # OAZI. LOUIS M 078Y 417883 ANJUM 6-17-17 man .

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the bospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | | CERTIFIC | ATE OF | DEATH | R | EG. NO. | | | | |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|------------------|-----------------------------------------|-------------------------------------------------------|-----|--|
| OR | 1. DECEDENT'S NAME (First, Middle, Last) WILDUT RUK | Crowe | | | 2. DATE OF E | DAY | YEAR | 3. TIME OF DE | HTA | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (I | Mr. | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B (Month, Day | 17, 199 | | 0520 HPLACE (State or | A M | |
| | | 1 M 2 □ F 89 | YRS. | | | April : | 17,1906 | Mary | land | | |
| | 90. FACILITY NAME (If not institution, give street Sacred Heart Hosp: | ital | | Dumber 1 | R LOCATION OF DE | EATH | 9c. co | egany | DEATH | | |
| 딥 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, CITY, 1 | OWN OR LOCAT | ON | | | | 10d. INSIDE CI | TV | |
| BY FUNERAL DIRECTOR | Maryland Allegar | | Midland | | | | | LIMITS? | | | |
| | 133 Paradise Stre | | | ZIP CODE 542 | | 10g. Cr | WHAT COUNTRY | 7 | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 27 IF YES, GIVE WAR OR DATES | | 2 NO | ARMED IS. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or if yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 VES 2 NO Specify: | | | | | to- 14. RACE — American Indian, Black, White, etc. | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade co | TION (mpleted) | 18e, DECEDENT'S US | DECEDENT'S USUAL OCCUPATION 16b. KIND O | | | | | | | |
| COMPLETED | Elementary/Secondary (0-12) | Itte. Do NOT use n | (Give kind of work done during most of working life. Do NOT use retired.) Sexton Churc | | | | | n | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Floyd E. Crowe | | | 16. MOTHER'S NA | o, Meiden Surneme) C Kenzie | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street ar | nd Number or Rural F | | | | | | |
| 2 | Edward J. Crowe | | | | aptown, M | | | p 5555) | | - 1 | |
| | 20e, METHOD OF DISPOSITION 1 Seriel 2 Cremetton 3 Remove | al from State came | PLACE AND DATE OF I | DISPOSITION (Nat | ne of | DATE | 20c. LOCATION - | | | | |
| | 4 Donation 5 Dotter (Specify) St. Joseph Cemetery Aug. 19, 1995 Midland, Md. 21542 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | Jos 5. 7/1 | Maje | | | orn-McKer | | | ome | | | |
| | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cardiec or respiratory arrest, ahock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | |
| Ì | disease or condition a. Hate Vneumontis days | | | | | | | | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| TIO | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| FIG | CAUSE (Disease or Injury CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | that initiated eventa resulting in dasth) LAST d. | | | | | | | | | | |
| L C | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part T. 24s. WAS AN AUTOPSY PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRODUCT PRO | | | | | | | | | | |
| DICAL | Congestive heart Failure. Sulidin al himoline PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | |
| ¥ | CoPD. Careinna Prostito Dementia 1 yes 2 UNO OF DEATH? | | | | | | | | | | |
| Ä | THIS ACCOUSE CONTRIBUTED TO CAUSE OF DEATH | | | | | | | | | | |
| SC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Minpetient 2 ER/Outpatient 3 DOA 4 Number from 5 Residence 8 Other (Specify) | | | | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | Minpetient 2 ☐ ER/Outpi | 28b. TIME C | | 5 Residence | | BE HOW INJURY OF | CCURED | | | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | INJURY WORK? M 1 YES 2 NO | | | | | | | |
| | 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY building, etc. (Speci | — At home, ferm, stre | et, fectory, office | | 261. LOCATION | | end Number or Aural Route Number, e) | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner as stated. | | | | | | | | | | |
| H | 296. SIGNATURE AND TITLE OF CERTIFIER Standbarre & 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) August 17. 1995 | | | | | | | | | | |
| 5 | SIKAN Der SANdhir M.D. 48 TARN Terrace Frastburg MD. 21532 | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | , - , , | | | 71 | - 17 | | | |
| | #U6 2 2 1995 | Jalia Davilso | H-March H | | | | | | | | |



| BALTIMORE, MARYLAND 21215-0020 | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within clours after death. Page 6 may be retained by the hospital or attending physicial | DIDECTOR. After this cartificate has been sinned by the otherwise and completely filled in by the funeral diseases seem & should be determined for use as the bounds. |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | nours after | filled in he th |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | requires that the death certificate be executed within | an cinear by the ottending phecician and completely |
| IVISION OF VITAL F | OR ATTENDING PHYSICIAN; The law n | NIDECTING. After this cartificate has he |

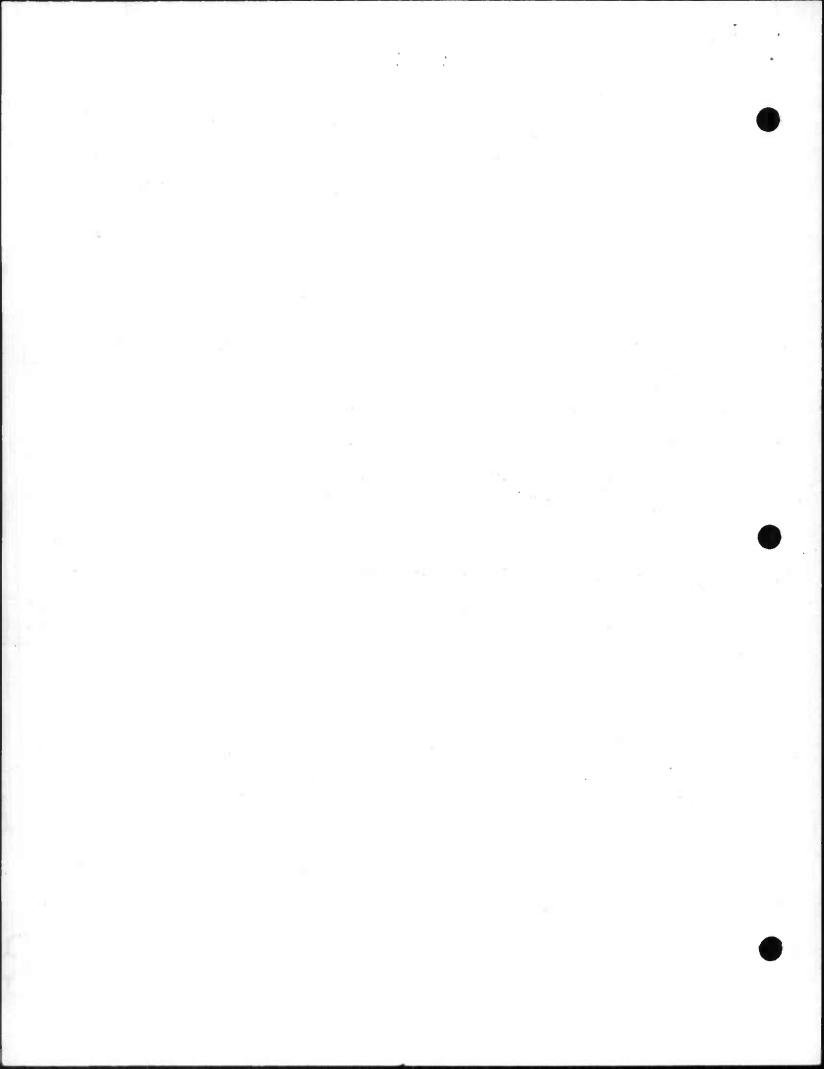
tending physician. as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thous after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR. After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYLA | | | F HEALTH | | ENTAL HYGIENE | | |
|--------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------|------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) JOHN | WILBERT CLA | | | | | 2. DATE OF DEATH AUGUST 20 | 1995 ^{EAR} | 3. TIME OF OEATH |
| | 4. SOCIAL SECURITY NUMBER | A | r yrs. last birthday) | IF UNDER 1 Y | EAR IF UNDER | 24 HRS. MIN. | 7. DATE OF BIRTH (Month, Day, Year) IAY 31 191 | a, Biff Cour | THPLACE (State or Foreign |
| | 217-10-7319 9a. FACILITY NAME (If not institution, give s | 70 | 1110. | 9b. CITY, TO | WN OR LOCATIO | | | 9c. COUNTY OF | |
| OR | 116 COLUMBIA STRE | EET | | CUMB | ERLAND | | | ALLEG | ANY |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | 1 | 10c. CIT | Y, TOWN OR L | OCATION | | | | 10d. INSIDE CITY |
| | | LEGANY | | UMBER | | | | | 1 YES 2 NO |
| FUNERAL | 116 COLUMBIA STE | REET | | | 2150 | | | U.S.A | WHAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yo | | n, Mexican, | ORIGIN? (Specify Yes of Puerto Rican, atc.) | Bla | CE — American Indian, ck, White, etc. ccty. WHITE |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16e. DECEDENT'S (Give kind of v life. Do NOT us | vork done duri | IPATION ng most of workin | g | 16b. KIND OF BUSI | INESS/INDUSTRY | 777.2.2.2.2 |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | STEAMFI | | | | STEAMF | ITTER | |
| SON | 17. FATNER'S NAME (First, Middle, Last) | | | | | | E (First, Middle, Meiden S | | |
| B | JOHN PETER CLARK 190. INFORMANT'S NAME (Type/Print) | | 405 MAH 1010 | ADDDESS (C | | | ELLEN PETE | | |
| 5 | ADA CLARK | | | | | | ute Number, City or Town, UMBERLAND | | D 21502 |
| | 20e. METHOD OF DISPOSITION 1 | | PLACE AND DATE OF | | | AUG | DATE 20c. LOC 20 1995 CU | ATION — City or IMBERLAN | Town, State D MARYLAND |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | . | | | | FUNERAL HO | | |
| | Pole 7. | Herrila | | | | | REET CUMBE | | ARYLAND |
| | | Emplications that caused Liet only one cause on ea | ch line. | | | | | atory arreat, | Approximate Interval Between Onset and Death |
| | iMMEDIATE CAUSE (Finel disease or condition resulting in death) | Ca | Lgester | e H | east F | arlu | re | | Dojears |
| z | | b. DUE TO (OP) A A | YVVLL | Helu | eat f | Selis | l | | 2 years |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | | | | | | | |
| TIFIC | CAUSE (Disease or injury that initiated evente resulting in death) LAST | OUE TO (OR AS A | CONSEQUENCE OF | 7): | | | 000 | Aug | ust 20, 1995 |
| | | d | | | | (| Jan Jo | | Paul Snow |
| PHYSICIAN: MEDICAL | PART II. Other significent condition | Sontributing to deeth bu | it not resulting i | n the unde | riying ceuse g | olven in Pa | ert I. 24s. WAS AN A PERFORM 1 YES 2 | MED? | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| A: ME | DID TOBACCO USE C | ONTRIBUTE TO | CAUSE OF | DEATH | YES 🖂 | NO | | | 1 YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Teleased 1 Yes 2 \sum NO | HOSPITAL: | 927 - 544 | OTHER: | 26. PLACE OF D | | | | |
| PHYS | 27. MANNER OF DEATN | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIM | - | c. INJURY AT WORK? | | Other (Specify) 28d. DESCRIBE NOW IN | JURY OCCURED | |
| Э ВУ | 1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be | 28s. PLACE OF INJURY | At home, ferm, a | | Office | | 281. LOCATION (Street en | nd Number or Rura | Route Number, |
| ETED. | 4 Nomicide determined | building, etc. (Speci | | | | | City or Town, State) | | |
| COMPLET | (Check only 1 M CERTIFYING PNYSI | CIAN: To the best of my knowle R: On the basis of examination | | | | | | | (a) and manner as stated. |
| B | 296. SIGNATURE AND TITLE OF CERTIFIES | 10 Ks CH | Fust! | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | 29c. L)CE | NSE NUMB | ER >2 | | D (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEA | TN (ITEM 27) (Type, | 910 | Lange Ma | +03 | and Dia | AUG Z | 1, 1995 |
| | RICHARD SCHMIDT 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | TURE P | <u> </u> | bella | ice | my dist | | |
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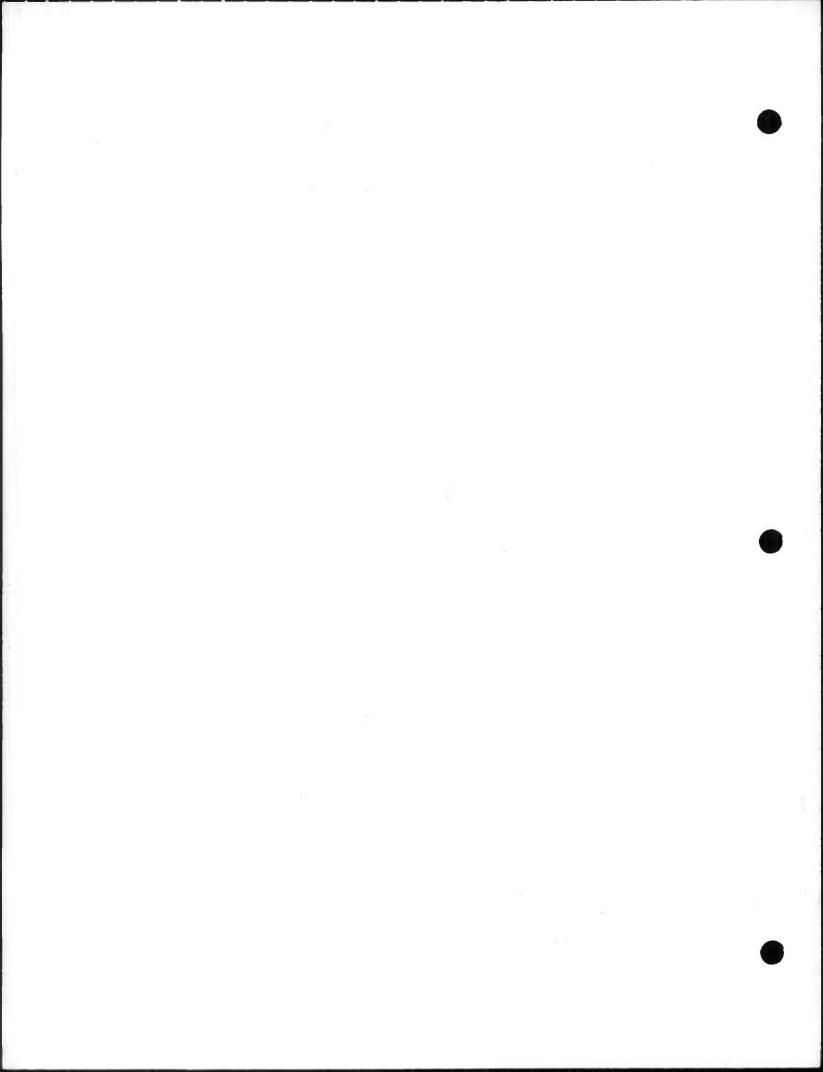
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 | FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral direct |
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| | HOSP | FUNE |

| | | 1 - STATE OF MARYLAND / DEPA REGISTRAR CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTI | RTMENT OF HEALTH AN | D MENTAL HYGIENE REG. NO. | | |
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| | | 1. DECEDENT'S NAME (First, MICCHO, Last) MARY LORRAINE CAMPION | V | 2. DATE OF DEATH AUGUST 267 | 1995 | 3. TIME OF DEATH 2015 M |
| - | | 4. SOCIAL SECURITY NUMBER 214-20-5067 5. SEX 8. AGE (in yrs. lest birthday) 1 \(\text{ M 2} \) 7 F 85 YRS. | MONTHS DAYS HOURS MIN | Character Consistence | 0. BIRTH | PLACE (State or Foreign |
| 2. 3 should | OR | 99. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL | 96. CITY, TOWN DR LOCATION O BERLIN | F DEATH | WORCEST | |
| Pages 1, | DIRECTOR | 10a. STATE 10b. COUNTY 10c. C | ITY, TOWN OR LOCATION SERL IN | | | 10d. INSIDE CITY LIMITS? |
| permit. | | 100. STREET AND NUMBER 530 BAY STREET | 101. ZIP CODE 2181 | 11 | 10g. CITIZEN OF W | |
| DZU physician. burial-transit | FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | 13. WAS DECENDENT OF NIS If yes, specify Cuben, Me | L J. SPANIC ORIGIN? (Specify Yee oxican, Puerto Rican, etc.) | or No- 14. RACE | — American Indian, White, etc. |
| T5-0020 ttending physic as the burial | ED BY | 31 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 15. DECEDENT'S EDUCATION 16e. DECEDENT | 1 TYES 2 THEO SE | 16b. KIND OF BUSI | Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Specific Spe | WHITE |
| -AND 21215-0020 the hospital or attending physician, detached for use as the burial-trar once. | PLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) HOMEMA | f work done during most of working use retired.) | Own Hom | | |
| 2 2 2 E | COMPL | 17. FATNER'S NAME (First, Middle, Liest) ADALORE CAMILLE GRANGER | | S NAME (First, Middle, Meiden St. | , | |
| make retained by 5 should be notified al | TO BE | 190. INFORMANT'S NAME (Type/Print) 190. MAILIN 530 | BAY ST., BERLIN | ural Route Number, City or Town, | | |
| 6 may be ector, page a | | 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE | eof disposition (Name of other place) | DATE 20c, LOCA | ATION — City or Ton | vn, State |
| BALLIMORE, s after death. Page 6 may by n by the funeral director, page removal. odical examiner must be | | 21. SIGNATURE OF FUNERAL SENSICE LICENSEE | 22. NAME AND ADDRESS OF | | | |
| th certificate be executed within 24 hou media physician and completely filled it hygiene prior to burial, cremation, or or other traumatic event, the me | CERTIFICATION | 23. PART Enter the diseases, or complications that ceused the death. Do shock, or heart feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of the conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of the conditions) of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the co | consider oriser original | such as cardiac or reapire | atory arrest, | Approximate Interval Between Onset and Death Quay Quay Quay Quay Quay Quay Quay Quay |
| at the country the by the sind Me | A P | PART II. Other algnificent conditions contributing to death but not resulting | in the underlying cause given | PERFORM | ED? | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE |
| has been sign Dept. of Healt | IAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DE | 'ES □ NO □ UNCERT. | AIN 🗆 | | OF DEATH? 1 YES 2 NO |
| | YSICI | EXAMINER? 1 YES 2 NO 1 Propertient 3 DOA | OTHER: 4 Nursing Home 5 Residen | ice 6 - Other (Specify) | | |
| F sit is | ву рну | 2 Accident Investigation | M 1 YES 2 ND | 28d. DESCRIBE HOW INJ | JURY OCCURED | |
| TTENDI TOR: A after d | ETED | 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm building, etc. (Specify) | street, factory, office | 28t. LOCATION (Street and City or Town, State) | d Number or Rural Re | oute Number, |
| 425 | COMPL | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occur one) 2 MEDICAL EXAMINER: On the best of examination end/or investigate | | | | end manner ea stated. |
| TO THE HOSPI TO THE FUNER be filed within | TO BE | 296. The Ature and Title of Certifier | 29c, LICENSE | | 29d, DATE SIGNED | (Month, Day, Ybar) 2 G 19 5 |
| | 2 | 30. NAME AND ADDRESS OF PERSON WHO COUPLETED CAUSE OF DEATH (ITEM 27) (Type Scott Sweeping DO (12) | e, Print) 10 BEALLIM | up RO Be | rlin 1 | 11312 61 |
| | | AUG 29 1995 Juli Senien Rudas | L | | | |



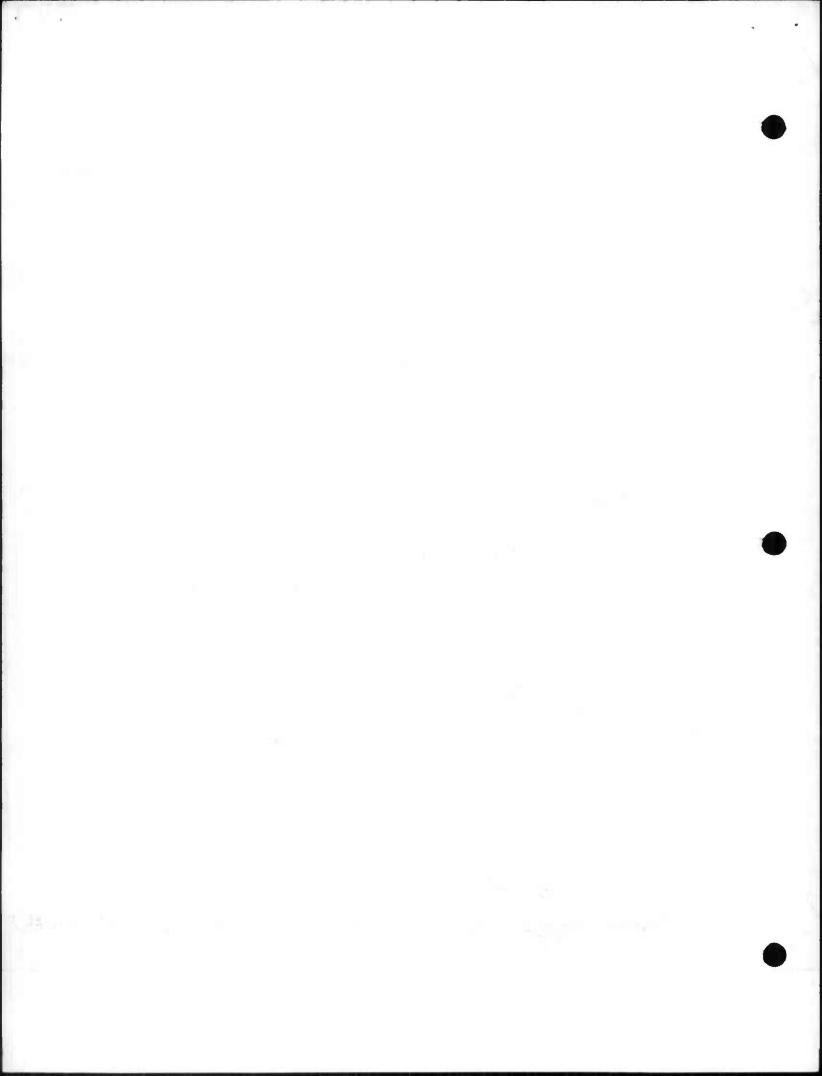
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| | | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPA | RTMENT OF I | HEALTH AND | MENTAL | HYGIENE REG. NO. | | |
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| | 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE O | | | 3. TIME OF DEATH |
| | | CLARA | FAYE | CLITE | | | Augu | st 23, | 1995 | 6:50 P |
| . <u>5</u> | | 4. SOCIAL SECURITY NUMBER 216-22-6735 | 1 🗆 M 2 🗶 F 81 | in yrs. lest birthday) YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE Of (Month) | P BIRTH Day, Year) | 8. BIPT Coun | HPLACE (State or Foreign try) PA |
| 3 should | Œ | 90. FACILITY NAME (If not institution, give st MEMORIAL HOSPITAL | | | 96. CITY, TOWN CUMBERI | OR LOCATION OF I | DEATH | | e. COUNTY OF ALLEGA | |
| . 2. | 6 | RESIDENCE OF DECEDENT | | | Cornellia | TAIN . | | | | |
| permit. Pages | DIRECTOR | 10e. STATE 10b. COUNTY | | 1 | TY, TOWN OR LOCATION | | | | | 10d. INSIDE CITY LIMITS? |
| rmit. | | MD Allec | Jany | Cur | mberland | H. ZIP CODE | | | - 07:3511 07 | YES 2 NO |
| 15 | ERA | 220 Somerville Av | zenije | | | 21502 | | | USA | WHAT COUNTRY? |
| -AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once. | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2X NO | 13. WAS DEC | CENDENT OF HISP/ pecify Cuben, Mexic 3 2 X NO Spec | can, Puerto Ric | (Specify Yee or can, etc.) | Spe | E — American Indian, ck, White, etc. city: White |
| 1215 attend | ED | 15. DECEDENT'S EDUC (Specify only highest grade | | 16e. DECEDENT'S | USUAL OCCUPATI work done during me | ON of weeking | 16b. I | CIND OF BUSINE | | WILL CE |
| of for u | COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | ise retired.) | | | | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | OME | 12 17. FATNER'S NAME (First, Middle, Last) | | Retire | d Seamst | 18. MOTNER'S N | | Clothin | | 5 |
| Y The de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se de la se della se de la se de la se de la se de la se de la se de la se de la se della se della se della se della se della se della se della se della se della se della se della se della se della se della | BE C | George Woomer | | | | | | onelsor | | |
| MAR retained 5 should notified | TO B | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | G ADDRESS (Street | | | | | |
| 5 5 5 | - | Richard V. Clites | | | Mt. Sava | | N; Mt | . Savad | ge, MD | 21545 |
| IORI e 6 may ector, p | | 20a. METHOD OF DISPOSITION 2 Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | val from State com | etary, crematory or i | OF DISPOSITION (N. other place) | | DATE | 6 Cumb | ON - City or T | |
| ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be | | 21. SIGNATURE OF FUNERAL SERVICE LIC | | inset Me | | ND ADDRESS OF F | ACILITY | | er rand, | FID |
| 0 = 0 | | James + | Scary | Ulli- | Cumbe | elli Fur erland, M | MD 21 | 502 | | |
| OX 68760 to be executed within 24 hours ician and completely filled in the nor to burial, cremation, or re- traumatic event, the medi | CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | Adenocarci DUE TO (OR AS A Chronic ob DUE TO (OR AS A Metastasis | noma of consequence of structing consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the | the lungue pulmon | g | | ic or reapirate | ory arreat, | Approximate Interval Between Onset and Death 2 yrs. 8 yrs. |
| S, P.O. B(death certificate that attending physient pri ental Hygiene pri nry, or other to | SERTIF | that initiated events resulting in death) LAST | | | | | | | | |
| RDS, at the dea by the atl and Menta y injury. | MEDICAL | PART II. Other aignificant conditions | contributing to death bu | ut not resulting | in the underlyin | g cause given in | - 1 | PERFORMES | 07 | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY |
| L RECO law requires th as been signed Dept. of Health 23 shows an | | DID TOBACCO USE CONTR | IBUTE TO CAUSE OF | DEATH Y | ES € NO □ | UNCERTAL | N 🗆 | | | 1 🗆 YEB 2X NO |
| VITAL F AN: The law bificate has be state Dept. | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINERT 1 YES 2 NO | | IS. PLACE OF DEA | TH /Check only one/ OTHER: | ne 5 🗆 Residence | | Consider | | |
| PHYSICIA this cert with the | / РНУ | 27, MANNER OF DEATH 1 Natural 5 Pending | 29s. DATE OF INJURY (Month, Deg. West) | 260. TIA | RE OF 260. INJ | HURY AT SHK7 | - | RIBE HOW INJUI | MY OCCURED | |
| DIVISION OF VITA. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The ITO THE FUNERAL DIRECTOR: After this certificate habe filed within 72 hours after death with the State DIMPORTANT: If Item 28 is marked, or Item 3 | ED BY | Accident Investigation Suicide 6 Could not be determined | 38e. PLACE OF INJURY building, etc. (Speci | — At home, farm, | | | 28f. LOCAT City or | ION (Street and / Stern, State) | Nuttiber or Flurei | Route Number |
| AL OR AT AL DIRECT Z hours a If item 2 | COMPLET | | IAN: To the best of my knowle | | | | | | | |
| UNER THIN | CO | 2 MEDICAL EXAMINED | On the basis of examination | and/or investigation | on, in my opinion, d | leath occured at the | e Time, date as | nd place, and du | ie to the cause(| i) and manner as stated. |
| THE F | BE | 296. BIGNATURE AND TITLE OF CENTIFIER | tun | 20 | | 29c. LICENSE NU | | | | (Month, Day, Yber) |
| 223 | 2 | 30. NAME AND ADDRESS OF PERSON WHO | | TN (ITEM 27) /5~~ | Prints | D 367 | 66 | | Augus | t 2 4 1995 |
| 4 | | Dr. Vik Poonai, 9 | | | | land. MD | 2150 |)2 | | |
| _ ′ | | 31. DATE FILED (Month, Dev. Year) | 32. BEGISTRAR'S SIGNA Jalia Davidso | TURE | , | , , , , , , | | | | |
| | | MUG NO 1933 | | we trainly | | | | | | |



(2)

| | 1 - STATE REGISTRAR | | STATE OF MARY | | TMENT OF HE | | ENTAL HYGIEN | | | |
|---------------|----------------------------------------------------------|----------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------|-----------------------------------|---------------------------------------------|--|
| 1 | 1. DECEDENT'S NAME (Firs | | | | | | DATE OF DEATH | MY YEAR | 3. TIME OF DEATH | |
| | ELI CLAYMON | | | | | | AUGUST 2 | 4 1995 | 4:00P | |
| | 217-10-2025 8a. FACILITY NAME (# not # | | 1 🖾 M 2 🗆 F | (In yrs. lest birthday) | MONTHS DAYS | HOURS MIN. | (Morth, Day, Year) UGUST 2, | 1901 NOF | RTH CAROLIN | |
| DIRECTOR | 504 PRISCIL | LA ST | | | SALISBUE | LOCATION OF DEAT | н | WICOMIC | | |
| | 10s. STATE MARYLAND | WICOM | • | | Y, TOWN OR LOCATION | N . | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 504 PRISCI | | REET | | 101. 2 | 21801 | | 10g. CITIZEN OF | WHAT COUNTRY? | |
| BY | 11. MARITAL STATUS 1 Never Married 2 2 3 Widowed 4 Dive | | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | 2 NO | If yes, spec | IDENT OF HISPANIC Ify Cuben, Mexican, I NO Specify: | ORIGIN? (Specify Ye Puerto Rican, etc.) | s or No — 14. RAC Blac Spec | E — American Indian, ok, White, etc. | |
| 밀 | | CEDENT'S EDU ly highest grade | | (Give kind of v | USUAL OCCUPATION work done during most | | 16b. KIND OF BU | ISINESS/INDUSTRY | | |
| PLET | Elementary/Secondary (| 0-12) | College (1-4 or 5+) | LABORE | | | POIII TI | DV | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) THOMAS CHILDRESS | | | | ER POULTRY 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLEMENTINE BLACKBURN | | | | | |
| BE | 19a. INFORMANT'S NAME (| | | 19b. MAILING | ADDRESS (Street and | | | | | |
| 5 | MOZELL L. S | CHOLL | | 513 P | RISCILLA | STREET, | SALISBUR | Y, MD 21 | 801 | |
| | 20g METHOD OF DISPOSIT | on 3 🗆 Rem | oval from State Ce | b. PLACE AND DATE OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF | OF DISPOSITION (Nam | CADDENG | | OCATION City or T | | |
| | 4 □ Donation S □ Office 21. SIGNATURE OF FUNEAU | | | STRINGUIL | | | | BRON, MAR | | |
| | VOAU | las | 43/16 | / | | | | | CEAN CITY | |
| \mathcal{T} | 23. PART 1. Enter the d | liseases, or | complications that cause | ed the death. Do r | | BOX 3171 | | | 21802 | |
| 7 | shock, or h | eart fallure. | List only one cause on | each line. | | | | | Interval Between Onset and De | |
| Ì | disease or condition resulting in death) | → | a. Heart DUE TO JOR AS | Failw | 1e | | | | 24 HOUF | |
| | | | DUE TO OR AS | D CONSEQUENCE OF | n: 11 a | mal | linea | -0 | | |
| NO. | Sequentially list condit if any, leading to imme | | b. DUE TO (OR AS | A CONSEQUENCE OF | P: V/C | 1100 | WV) Car | <i>)</i> | 11 YEAF | |
| CAT | cause. Enter UNDERLY CAUSE (Disease or Inic | ING | c | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAS | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| 8 | | | d | | | | | | | |
| SAL | PART II. Other algniffica | nnt condition | Recent | but not reaulting | in the underlying | cause given in Pa | rt I. 24a. WAS AN PERFO | RMED? 24 | b. WERE AUTOPSY FINDIN MAJLABLE PRIOR TO | |
| EDIC | CIA C | VIT | Advani | | Bladd | 9 | _ 1 TYES | 2 (N/NO | OF DEATH? | |
| Σ | swy | 17/ | 1101 WAL | 201 11 | | | - 1 | | 1 TYES 2 NO | |
| CIAN: | 25. WAS CASE REFERRED 1 EXAMINER? | O MEDICAL | MOCRITAL | | | CE OF DEATH-Check | only one) | | | |
| HYSICI | 1 NES 2 □ NO | | HOSPITAL: 1 Inputient 2 ER/Out | tpatient 3 DOA | OTHER: 4 Nursing Home | 5 Residence 6 | Other (Specify) | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 | Pending | 28a, DATE OF INJURY (Month, Day, Year) | 28b. TIM INJ | URY WOR | (7 | Id. DEŞCRIBE HOW | INJURY OCCURED | - | |
| 0 8 | 2 Accident 3 Suicide | Investigation Could not be | 28e. PLACE OF INJUR | Y — At home, farm, r | | S 2 10 NO 2 | BI, LOCATION (Street | and Number or Rural | Route Number | |
| ETEC | 4 Homicide | determined | building, etc. (Spi | вспу) | | | City or Town, State |) | | |
| ۲ ا | 29a. CERTIFIER (Check only | TIFYING PHYSI | ICIAN: To the best of my know | wiedge, death occurre | ed at the time, date a | nd place, and due to | the cause(s) and ma | nner se stated, | | |
| COM | | | ER: On the basis of examinati | | | | | | s) and manner sa stated | |
| 띪 | 29b. SIGNATURE AND TITLE | | Wag A | _ | | DIS6 | 14 | 29d. DATE SIGNED | 30/95 | |
| 2 | 30. NAME AND ADDRESS O | F PERSON WH | O COMPLITTO MUSE OF D | EATH (ITEM 27) (Type | Print) Q 1 2 | er Zi A. | o.Da | Solie | being 1 | |
| | ~~~ ~~ ~~ ~~ ~~ ~~ ~~ ~~ ~~ ~~ ~~ ~~ ~~ | 7 7 1 1 1 | | ~ / / | | A C 31 / 1 E | | | | |
| | 31. DATE FILED MANON | 1944 100 | 32. REGISTRARY SIG | NATURE P | 1 | 1010 | | 3,0(1) | ~ 0,4, | |

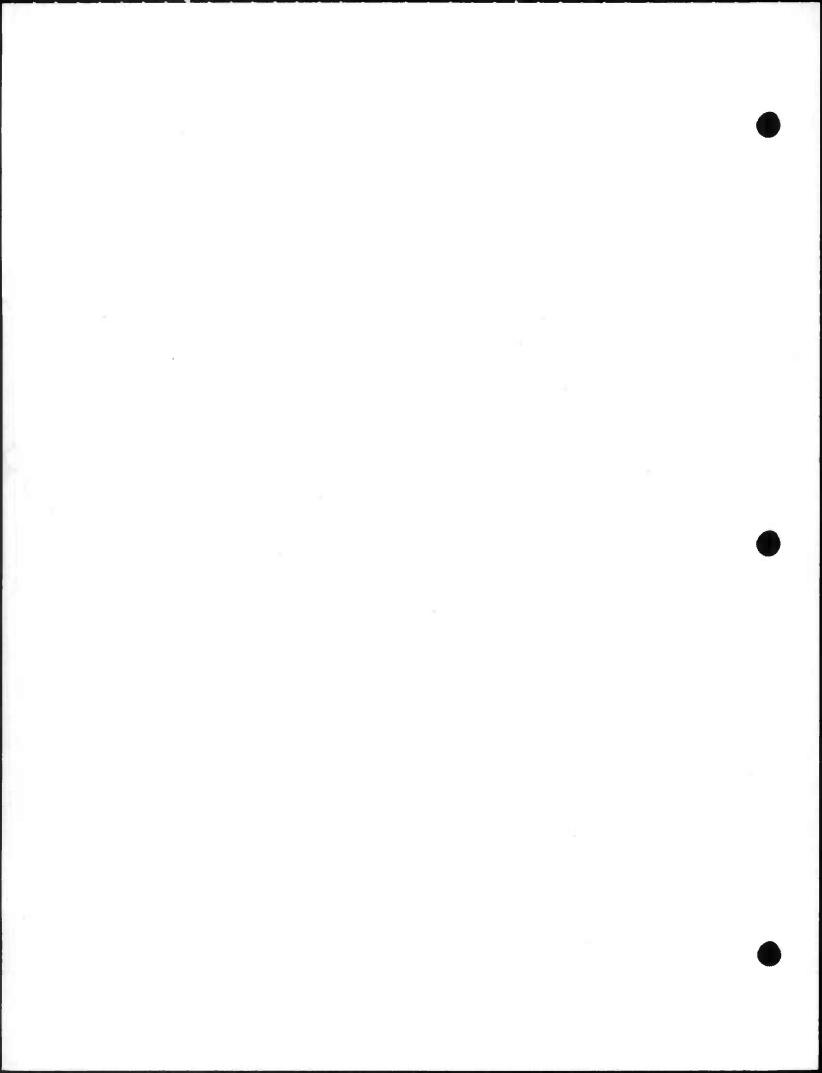


permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer | De Hied within 12 hours are dearn with the State Dept. of Hearth and Merital Hyghere phor to oursal, cremation, or removal. | IMPORTANT: If Nom 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| | , , | 0 | |

| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND / | | | | IEALTH DEAT | | MENT | AL HYGIE | | | |
|-------------------------------------------------------------------------------|------------------------------------------------------|-----------------|--------------------|---------------------|--------------|---------------------------|-------------|----------------|-----------|--------------|----------------------|--------------|------------|-------------------------------------------|
| | 1. DECEDENT'S NAME (First, Mid | ddle, Leet) | | | | | | | | | E OF DEATH | | | 3. TIME OF DEATH |
| | RICHARD KI | ENNE | ГH | DER | N | | | | | MON Δ11 O | ust 23 | DAY 199 | YEAR | 6:32 A. |
| | 4. SOCIAL SECURITY NUMBER | | 6. SEX | 6. AGE (In yrs. les | | | I YEAR | IF UNDER | | 7. DAT | E OF BIRTH | | e. BIRTH | PLACE (State or Foreign |
| | 214-07-3848 | | 1 X M 2 - F | 84 | YRS. | MONTHS | DAYS | HOURS | MIN. | | 11h, Day, Year) | 11 | Country | |
| | 9a. FACILITY NAME (If not institu | rtion, give atn | eet and number) | | | 96. CIT | r, TOWN (| R LOCATI | ON OF D | | J, 1 | | NTY OF DE | MD EATH |
| DIRECTOR | Memorial Host | oital | & Medic | al Cente | er | Cumb | erla | and | | | | Alle | gany | |
| EC | | b. COUNTY | | | _ | Y, TOWN | | | | | | | T | 10d. INSIDE CITY |
| H | MD | Alle | Tanti | | | | | | | | | | - 1 | LIMITE? |
| | 10s. STREET AND NUMBER | 711100 | july | | Cu | mber | | ZIP COD | F | - | | I 100 CITI | | 1- YES 2 NO |
| FUNERAL | 112 Cominada | ים בר | | | | | 100 | | | | | | | nat cooking? |
| 3 | 112 Springda | ite 21 | 12. WAS DECEDEN | IT EVER IN U.S. AR | RMED | 13 | | 21502 | | NIC OBIO | IN? (Specify Y | USZ | | A-0.00 - 1-00 - |
| | 1 Never Married 2 Mar | | FORCES? 1 | YES 2 X | NO | - 1 | If yes, sp | ecify Cubs | n, Maxica | in, Puerto | Rican, etc.) | a or No— | | - American Indian, White, etc. |
| В | 3 Widowed 4 Divorced | 4 | IF TES, GIVE V | WIN ON DATES | | | I YES | 2 X NO | Specif | у: | | | Specify | |
| COMPLETED | 15. DECEDE (Specify only hig | NT'S EDUC | ATION | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | ON . | | 18 | b. KIND OF BU | JSINESS/IND | | hite |
| <u> </u> | Elementary/Secondary (0-12) | | College (1-4 or 5 | Ho | . Do NOT u | work done se retired.) | during mo | st of worldr | 10 | - | | | | |
| 린 | 12 | | | Re | etire | d | | | | | Texti | le | | |
| Ö | 17. FATHER'S NAME (First, Middle | s, Last) | | | | | | 18. MOTI | HER'S NA | ME (First, | Middle, Maide | | | - |
| BE | Edward Wi | lliam | Dern | | | | | Δ | nnie | 1Cc | paklev | | | |
| 2 | 19s. INFORMANT'S NAME (Type/ | | | 191 | b. MAILING | ADDRES | S (Street a | | | | mber, City or To | | Code) | |
| ۴Į | Harold F. Wa | alters | 3 | 42 | 04 Dr | ch S | troc | +. 0 | mbo | wl ar | od. MD | 215 | n 2 | |
| | 20e, METHOD OF DISPOSITION 1 Duriel 2 Cremetion | | and described as | 20b. PLACE | AND DATE | OF DISPOS | SITION (Na | | | OA | | OCATION — | | rn, State |
| | 4 Donation 5 Other (Spe | ecity) | val from State | cametery, cre | | | | Dark | | 08/ | /25 Cu | mberl | and | MD |
| | 21. SIGNATURE OF FUNERAL SE | ERVICE LICE | NSEE | | . / | 22. | NAME AP | D ADDRES | SS OF FA | CILITY | | HOCLI | .cara, | T.II. |
| | 1 1/0000 | 7 | Ma | .001 | // . | S | carp | elli | Fun | eral | L Home | | | |
| \dashv | 23. PART I. Enter the disea | 7 | The land the | eypei | 11 | | umbe | rlan | d. M | D 2 | 21502 | | | |
| | anock, or neart | fallure. L | let only one cau | iee on each line |), | not enter | the mo | de or dyl | ng, suc | h aa cai | rdisc or resp | oiratory arr | es1, | Approximate interval Batween |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | | Onset and Déath |
| ŀ | resulting in death) | | PULMONA | (OR AS A CONSE | | | | | | | | | | 15 DAYS |
| | | | | | | | DIMI | <i>a</i> | | | | | | |
| o | Sequentially list conditions | | DEEP VEI | OR AS A CONSEC | | | RITI | S | | | | | | 3 WEEKS |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | | CORONARY | | | | CD A | אוא דיייינו | 0 | | | | | / |
| 띮 | CAUSE (Disease or injury that initieted events | 6 | | (OR AS A CONSEC | | | GRA | ETTM | 3 | | | | | 4 WEEKS |
| | resulting in death) LAST | | | | | | | | | | | | | İ |
| 빙 | | 0. | | | | | | | | | | | | + |
| A | PART II. Other algolificent of | conditions | contributing to | deeth but not r | reaulting | In the ur | derlying | ceuse g | jiven in | Part I. | 24a. WAS AI PERFO | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| 용네 | | | | | | | | | | | 1 YES | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | | | | | OF DEATH? |
| <u>.</u> | DID TOBACCO USE | CONTR | BUTE TO CA | USE OF DEA | TH YE | S 🔲 | NO 🔽 | UNC | ERTAI | V 🗆 | | | | |
| 8 | 25. WAS CASE REFERRED TO ME EXAMINER? | | | 26. PLAC | E OF DEA | TH (Check | only one) | | | | | | | |
| š | 1 WES 2 WO | | HOSPITAL: | ER/Outpetlant 3 | □ DOA | OTHER | | 6 🗆 Re | eldence | 6 🗆 Oth | et (Specify) | | | |
| PHYSICIAN: MEDICA | 27. MANNER OF DEATH | | 26a. DATE OF | | 28b. TIM | E OF | 28c, INJ | JRY AT | | | SCRIBE HOW | INJURY OCC | UREO | |
| | | | | | | | | | | | | | | |
| 2 Accident investigation 26c PLACE OF IN HIGH. At home for stord factor Miles | | | | | | | | ute Number, | | | | | | |
| COMPLETED | | rmined | bunding, | вил (орвсну) | | | | | | City | or Town, State |) | | |
| וב | 290. CERTIFIER 1 CERTIFY | NG PHYSICI | AN: To the best of | my knowledge de | ath occurs | ad at the t | ime dete | and place | and due | to the co | | | 4 | |
| Š | | | | | | | | | | | | | | and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF | | 1 | | | | | | | | _ one prece, s | | | |
| 2 | 1113110 | X | 1. | 10 4 | | | | 29c. LICE | NSE NUN | ABER . | | | | Month, Day, Year) |
| 2 | 30 NAME AND ADDRESS OF RES | , , | compression | n m | ノ | 2: | | D 25 | 406 | | | Aug | ıst • | 23, 1995 |
| | 30. NAME AND ADDRESS OF PER | OHW NUCE | COMPLETEO CAUS | SE OF DEATH (ITER | W 27) (Type, | Print) | | | | | | | | |
| | Dr. William I. 31. DATE FILED (Month, Day, Year) | | 47 Virg | inia Ave | nue | Cum | ber1 | and. | MD | | 21502 | | | |
| | | 4 1 | dividual so | R'S SIGNATURE | | | | | | | | | | |
| | aug 25 1995 | 1 | | | | | | | | | | | | |



1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

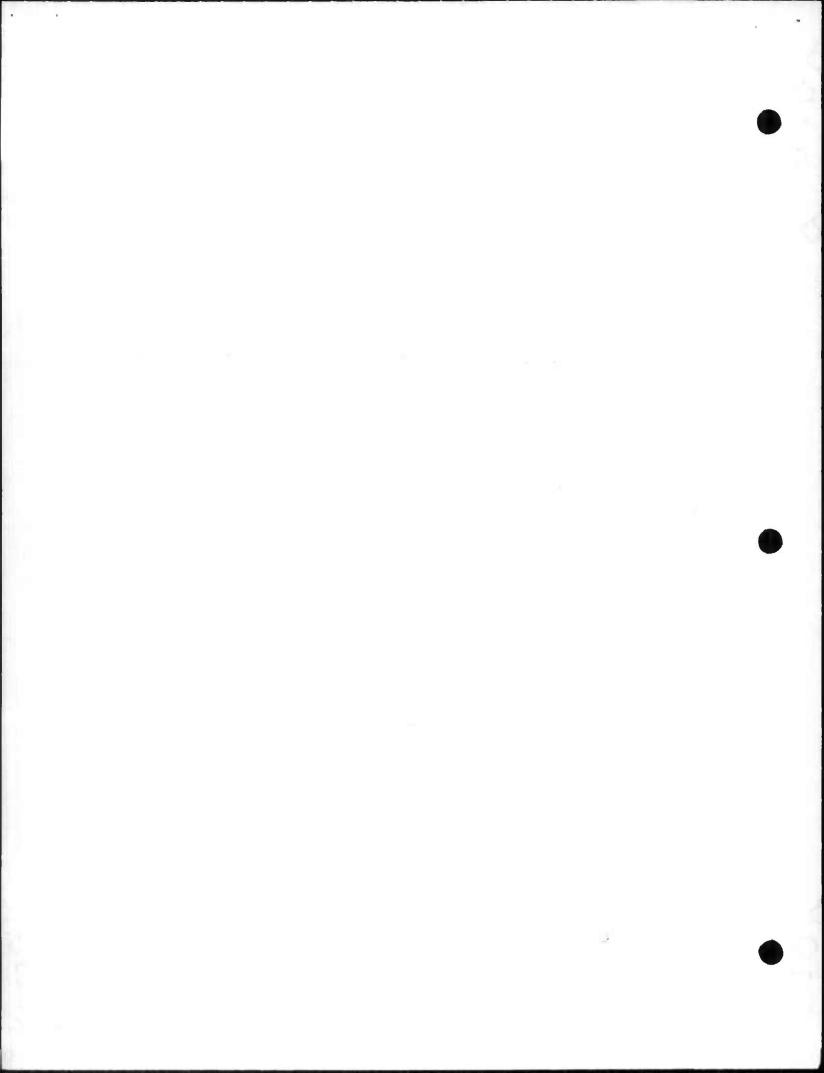
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traum: | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | CODR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages after death with the State Dent of Health and Mental Hymiens now in hurial cremation or removal | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALTH | | HYGIEN REG. NO. | _ | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DATE OF DEATH | | 3. TIME OF DEATH |
| TS A TA H | LOUIS 5. SEX 6. AGE | DIE | | | 9/1/9 | 5 | 3:30 p. |
| None | 1 📉 M 2 🗆 F | YRS. | STUDEN STAND | MIN. | Month, Day, Year) 9-1-95 | 8. | BIRTHPLACE (State or Foreign Country) Maryland |
| NATIONAL NAV | | CENTER | BETHES | SDA | | | NTGOMERY |
| 10a STATE 10b COUNT | airfax | 10c. CITY, | TOWN OR LOCATION Spri | | d | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 8161 Curving Cr | eek Ct. | | 10f, ZIP CO | 22153 | | 10g. CITIZEI | N OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED 2 X NO DATES | 13. WAS DECENDENT If yes, specify Cut 1 YES 2 NO | en, Maxican, Pu | RIGIN? (Specify Yes arto Rican, etc.) | or No- 14 | Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDU (Specify only highest grade | | 16a, DECEDENT'S U (Give kind of wo | rk done during most of work | sina | 16b. KIND OF BUS | SINESS/INDUS | TRY |
| Elementery/Secondary (0-12) None | None | ille. Do NOT use | retired.) None | | None | | |
| 17. FATHER'S NAME (First, Middle, Last) | Cardaland I Di | | | | irst, Middle, Meiden | | |
| 19a. INFORMANT'S NAME (Type/Print) | erbert L. Di | | | | Lemalle | | |
| Herbert L. D | ni ew | | DDRESS (Street and Numb Curving Cre | | | | |
| 20e. METHOD OF DISPOSITION 1 | 201 | b. PLACE AND DATE OF | DISPOSITION (Name of | T | DATE 20c. LO | CATION — CIT | y or Town, Stete |
| 21. SHANATURE OF FUNERAL SERVICE LECENSES 22. NAME AND ADDRESS OF FACILITY Arlington Fune 3901 N. Fairfax Dr. Arlington | | | | | | | Funeral Home |
| 23. PART i. Enter the diseases, or ahock, or heert feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. EXTREME | esch line. | URITY | ying, such ss | cardiac or respir | ratory srres | t, Approximate interval Betwee Onset and Deat |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | с | A CONSEQUENCE OF): | | | | | |
| PART II. Other significant condition | s contributing to death t | out not resulting in | the underlying ceuse | given in Part | i. 24a. WAS AN PERFOR 1 _ YES 2 | MED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| DID TOBACCO USE CONT | RIBUTE TO CAUSE C | OF DEATH YES | | CERTAIN [|] | | 1 TYES 2 NO |
| EXAMINER? | HOSPITAL: | | OTHER: | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Noperlient 2 ER/Outpetlent 3 DOA 4 Nursing Home 5 TO North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control North Control Nort | | | | | . DESCRIBE HOW IN | NJURY OCCUP | RED |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, atc. (Spe | f — At home, ferm, etc. | est, factory, office | 261. | LOCATION (Street a City or Town, State) | and Number or | Rural Route Number, |
| | CIAN: To the best of my know R: On the bests of examination | | | | | | suse(s) and manner as stated. |
| 290. GIGNATURE AND TITLE OF CERCIFIE | 'lus | | MP | CENSE NUMBER | TN 25589 | D 09 | IGNED (Month, Day, Year) 1-02-95 |
| DEDT TAVIO | R. CPT. M.C. | _uc_loal | H. Zeller | NATION BETHI | NAL NA ESDA, M | VAL M D 208 | EDICAL CEN 889-5600 |

A REGISTRAR'S SIGNATUSE

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| | 1 - STATE REGISTRAR | STATE OF M | ARYLAN | D / DEPAR CERTIF | TMEN | T OF H | IEALTH DE AT | AND | MENTA | L HYGIE | | | | |
|------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|-----------------|-----------|------------|-------------------------------|---------------------|--------------|---------------------------------------|-------|
| | 1. DECEDENT'S NAME (First, Middle, L | est) | | | | | DEA | | 2. DAT | E OF DEATH | 0. | | 3. TIME OF DEAT | Н |
| | Ivry Matthew I | Davidson Sr. | | | | | | | MON | | 6 7 Q | YEAR | 11:08 | Дм |
| | 4. SOCIAL SECURITY NUMBER | | | s. last birthday) | IF UNDER | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | OF BIRTH | 1.9. | | IPLACE (State or Fo | |
| | 208-01-9801 9s. FACILITY HAME (If not Institution, g | 1½ M 2 🗆 F | 84 | YRS. | MONTHS | DAYS | HOURS | MIN. | FEB | th, Day, Year) | , 1911 PENNSYLVANIA | | | |
| <u> </u> | | | POTNI | r | | | POTN | | EATH | | | UNTY OF D | EATH | |
| 6 | DOD GUM GEMAN | | | | | | | | | | | | | |
| # | | | | | | | | | | | 10d. INSIDE CITY | | | |
| FUNERAL DIRECTOR | MARYLAND DORCHESTER LINKWOOD | | | | | | | | | | | 1 TYES 2 X | но | |
| ¥ | 10e. STREET AND NUMBER | A.D. | | | | 101 | . ZIP CODI | | | | 10g. CI | | WHAT COUNTRY? | |
| N | 3817 VINCENT RO | | | | | | 2183 | | | | | USA | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 R OR DATES | S. ARMED | | If yes, sp | | n, Mexico | en, Puerto | N? (Specify Y Rican, etc.) | es or Ho- | Spec | | in, |
| | 15. DECEDENT'S | WWII | 10. | . DECEDENT'S | UCUAL O | COLIBATIO | | | - | | | WHI | TE | |
| | (Specify only highest of Elementary/Secondary (0-12) | grade completed) | | (Give kind of v | work done | during mo | st of working | g | 16 | b. KIND OF B | USIHESS/IN | DUSTRY | | |
| COMPLET | 10 | College (1-4 or 5+) | | TRUCK | DRIV | ER | | | | ransi | ORTA | TION | | |
| Š | 17. FATHER'S HAME (First, Middle, Last |) | | | | | 18. MOTI | HER'S HA | ME (First, | Middle, Maide | n Surneme) | | | |
| DE C | IVRY MATTHEW DA | VIDSON | | | | | | MA | GGIE | MURPH | ΙY | | | |
| 5 | 19s. IHFORMANT'S HAME (Type/Print) | | | 19b. MAILING | | | | | | | | ip Code) | - | |
| - | BRENDA J. LARRI | MORE | | 381 | 7 VI | NCEN | T RO | AD, | LIN | KWOOD, | MD | 2183 | 35 | |
| | 20s. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify) | Ramoval from State | cemeter MD F | ACE AND DATE OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENTRAL PROPERTY OF A CENT | her place) | RE V | me of FT. | CEM | DAT | 18 BEI | OCATION - | - City or To | Wn, Stata | |
| į | 21. SIGNATURE OF FUNERAL SERVICE | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. HAME AND ADDRESS OF FACILITY | | | | | | | | | | | | |
| | ZELLER FUNERAL HOME, P. O. 1 106 MAIN STREET, EAST NEW M | | | | | | | | | | | 531 | | |
| 4 | 25. PART I. Enter the diseesea, | of complications that | caused the | death. Do n | ot enter | the mo | de of dyi | ng, suc | h ea cer | diac or res | piratory a | rrest, | Approxima | ile |
| | IMMEDIATE CAUSE (Final | ore. Cler Drily Orie Ceus | e Du emcu | line. | | | | | | | | | Interval Be Onset and | |
| | disease or condition resulting in death) | Conge | stive | Heart | Fai | luce | 9 | | | | | | 3 wee | eks |
| | | DUE TO (C | OR AS A CO | NSEQUENCE OF | 7): | | | | | | | | | |
| 5 | Sequentially list conditions, | ь | | | | | | | | | | | | |
| A I ION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (C | OR AS A CO | NSEQUENCE OF | ·): | | | | | | | | | |
| = II | CAUSE (Disease or injury that initiated events | c. DUE TO (C | OR AS A CO | HSEQUENCE OF |): | | | | | | | | | |
| באוו | resulting in death) LAST | 4 | | | | | | | | | | | į | |
| 2 | BARY II Oshan alamidiana and di | d. | | | | | | | | | | | | |
| ₹∥ | PART II. Other aignificent condi | Itions contributing to d | eeth but n | not resulting i | n the ur | derlying | cause g | jiven In | Part I. | | N AUTOPSY ORMED? | 24b | WERE AUTOPSY FII AVAILABLE PRIOR | го |
| MEDIC | | | | | | | | | | 1 TYES | 2 📉 NO | | OF DEATH? | AUSE |
| | DID TODA CCO LICE CO. | ALTOIDUTE TO CALL | | | | | | | | | | | 1 - YES 2 X N | ю |
| | DID TOBACCO USE CO | | | PLACE OF DEAT | | | UNC | ERTAI | ΝЦ | | | | | |
| TSICIAN | EXAMINER? 1 YES 2 HO | HOSPITAL: | | | OTHER | ₹: | - 173 - | 1971 | | ar and | | | · · · · · · · · · · · · · · · · · · · | |
| É | 27. MAHNER OF DEATH | 28a. DATE OF III | | 28b. TIM | | 28c. INJ | | sidence | | er (Specify) SCRIBE HOW | IH-IURY OC | CURED | | |
| | 1 Hetural 5 Pending | (Month, Day | Yesr) | INJ | URY M | WO | RK? | NO | | | | 701125 | | |
| 3 | 2 Accident investigati 3 Suicide 8 Could not | 28e. PLACE OF | INJURY - A | At home, farm, s | treel, lact | ory, office | | | | CATION (Stree | | or Runal F | Route Number, | |
| | 4 Homicide determine | | с. (эрвспу) | | | | | | City | or Town, Stat | e) | | | |
| | 29a. CERTIFIER (Check only 1) CERTIFYING PI | HYSICIAN: To the best of m | y knowledge | e, death occurre | d at the t | lme, dets | and placs. | and due | to the ca | use(s) and m | enner as sta | rted. | | |
| 5 | | WINER: On the besis of axa | | | | | | | | | | |) and menner ss st | ated. |
| 2 | 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Da | | | | | | | | | | | | | |
| | | | | | | | | | gust 199 | 5 | | | | |
| | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE | OF DEATH | (ITEM 27) (Type, | Print) | | | | | | | | | - |
| | Kenneth Mills- | Robertson, | M.D. | VAMC | Perr | у Ро | int, | MD | 2190 |)2 | | | | |
| | 31. DATE FILED (MONTE DE 100 1 | 1995 32. RECHSTAR | SHENATU | Excharda | Ц, | | | | | | | | | |
| | 051 0 1 | 0 | | | | | | | | | | | | |



Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTA CERTIFIC | | | MENTAL HYGIEN | _ | | | | | | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------|-----------------------------------------|-----------------------------------------------|----------------------------------------|-------------------|--------------------------------------------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | | |
| | Lillie V | Virginia E | bling | | | 07 26 | | | | | | | | |
| | | | (In yrs. last birthday) F | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. B | HRTHPLACE (State or Foreign | | | | | | |
| | 214-74-3528 1 9a. FACILITY NAME (If not institution, give street | | 101 YAS. | DAYS | HOURS MIN. | March 21, 1 | | aryland | | | | | | |
| DIRECTOR | Caroline Nursing H | lome | | Denton | , MD | Caroline | | | | | | | | |
| HEC | 10e. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCAT | ION | | 10d. H | | | | | | | |
| | Maryland Carol | line | R | idgely | ZIP CODE | | 10- CITIZEN | LIMITS? 1 ▼ YES 2 □ NO OF WHAT COUNTRY? | | | | | | |
| FUNERAL | Central Ayenue | | | 101 | 21660 | | U.S | | | | | | | |
| S | 11. MARITAL STATUS 12 | RACE - American Indian, | | | | | | | | | | | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | | | city Cuban, Maxica 2 NO Specify | n, Puerto Rican, etc.) | | Black, White, etc. | | | | | | |
| D BY | 3 Widowed 4 Divorced | | | | | | l c | aucasian | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATI (Specify only highest grade com | | (Give kind of work | done during mos | IN st of working | 16b, KIND OF BUS | SINESS/INDUSTR | RY | | | | | | |
| J.E | | College (1-4 or 5+) | life. Do NOT use re | | | | | | | | | | | |
| MC | 17. FATHER'S NAME (First, Middle, Lest) | | Homema | aker | 18 MOTHER'S NA | ME (First, Middle, Maiden | | | | | | | | |
| | Walter J. | Cohoo | | | | | Surname) | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | Conee | 19b. MAILING AD | DRESS (Street a | | C. Hobbs Route Number, City or Town | n. State Zin Code | 0) | | | | | | |
| 5 | Arthur E. Ebling | | | | | | | land 21660 | | | | | | |
| | 20s. METHOD OF DISPOSITION 3 Buriel 2 Cremetion 3 Removal | 20b | PLACE AND DATE OF D | ISPOSITION (Na | | | CATION — City of | | | | | | | |
| | 4 Donation 5 Other (Specify) | | etery, cremetory or other enton Ceme | | | 7/29 Der | nton. M | arvland | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. | | | | | | | | | | | | | |
| | I belie and | Must | re | | | | | 21.600 | | | | | | |
| | 23. PART I. Enter the diseesea, or com | plicetions that caused | the deeth. Do not | enter the mo | de of dying, suc | Denton, Ma | ratory srrest, | Approximate | | | | | | |
| | ahock, or heert failure. Liet only one cause on eech line. IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | | | |
| | appear and an appear of | | | | | | | | | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF): | 1 | 1 | | | 0 | | | | | | |
| N | resulting In death) a. De hy diraction Due ty (or as a conscouence of): Mutationgau failure Sequentially list conditions, | | | | | | | | | | | | | |
| ATIO | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | | | |
| 5 | CAUSE (Disease or injury \$ c | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | that initiated evente resulting in deeth) LAST | | | | | | | . i . | | | | | | |
| | d | | | | | | 100 | | | | | | | |
| AL | PART II. Other significant conditions co | ontributing to death b | ut not resulting in t | he underlying | | Part I. 24e. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | | | |
| MEDIC | | - Yrina | rry ju | recl | 100 | 1 YES 2 | - DIMO | COMPLETION OF CAUSE OF DEATH? | | | | | | |
| ME | Coronary & | artery | 845 | eas | 0 | | | 1 TES 2 -40 | | | | | | |
| N. | DID TOBACCO USE CONTRIB | | | □ NO ⊡ | UNCERTAIN | 10 | | | | | | | | |
| PHYSICIAN: | | OSPITAL: | | гнея: | 13 10 24 | | | | | | | | | |
| ¥S | 1 YES 2 -40 1 27. MANNER OF DEATH | Inpatient 2 ER/Outp | atient 3 DOA 4.5 | | | a Other (Specify) | | | | | | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJURY | | RK? | 28d. DESCRIBE HOW II | NJURY OCCURE | P | | | | | | |
| BY | 2 Accident Investigation 3 Suicida & Could not be | 28s. PLACE OF INJURY | - At home, term, stree | | | 28f. LOCATION (Street a | and Number or Ru | vral Bruta Number | | | | | | |
| | 4 Homicide 8 Could not be determined | building, etc. (Spec | effy) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or Town, State) | TO THE THE | var riouse realization, | | | | | | |
| " | 29a. CERTIFIER | | lades death secured a | the time date | ariotal incide | | = -001-01 | | | | | | | |
| - | 1 CERTIFYING PHYSICIAN | | | | | | | | | | | | | |
| MP. | (Check only | N: To the best of my knowl on the besis of examination | | my opinion, de | and due to the cause(a) and menner as stated. | | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: O | | | n my opinion, de | | | | | | | | | | |
| BE | (Check only | | | my opinion, de | 29c. LICENSE NUN | | | NED (Month, Day, Year) | | | | | | |
| | (Check only one) 2 MEDICAL EXAMINER: O | on the basis of examination | n and/or Investigation, Ir | 70 | | | | | | | | | | |
| BE | (Check only 1 CENTIFTING PHYSICIAN ONe) 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER | on the basis of examination | n and/or Investigation, Ir | 7) | 29c, LICENSE NUM | MBER 76 | 29d. DATE SIG | | | | | | | |
| BE | (Check only 1 CENTIFTING PHYSICIAN ONe) 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER | on the beals of examination OMPLETED CAUSE OF DEA | an and/or Investigation, Ir | 7) | 29c, LICENSE NUM | | 29d. DATE SIG | | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

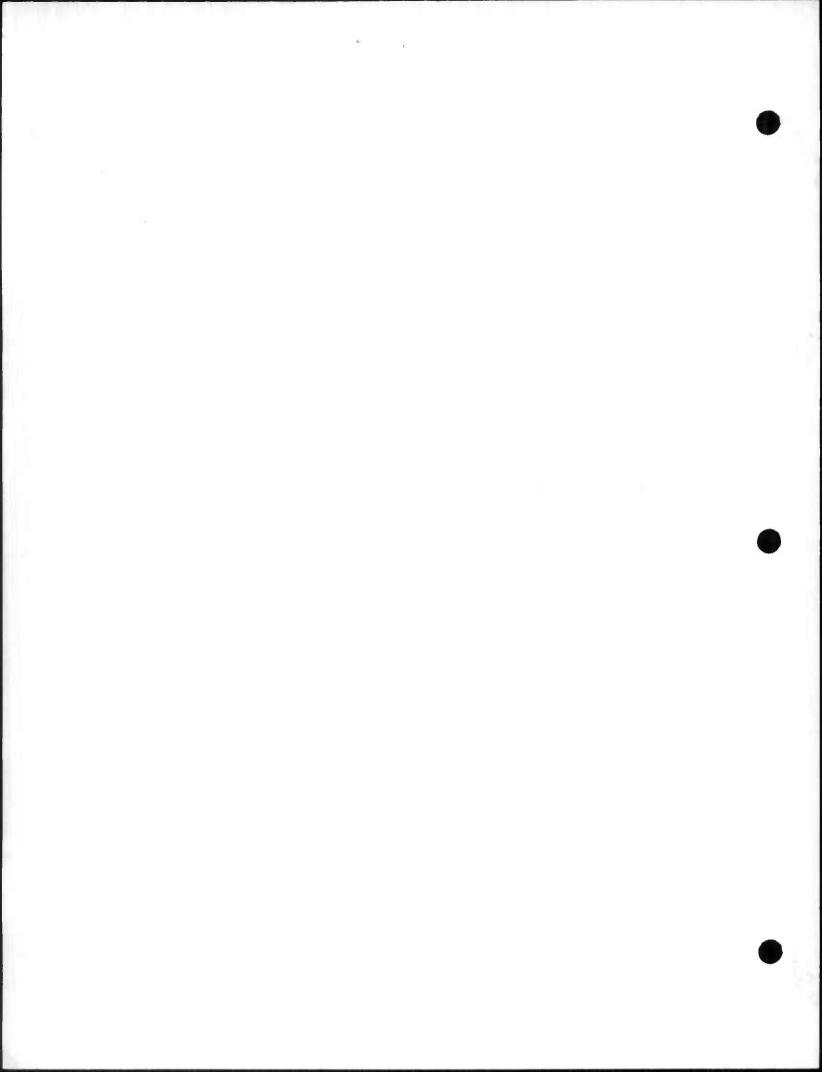
| | FOR STATE OF MARYLAND / DE STATE OF MARYLAND / DE CER' | | OF HEALTH AND | MENTAL HYGIENE REG. NO. | E | | | | | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | 1,515 | 3. TIME OF DEATN | | | | | | | |
| | Ryan Paul Fedderly | | | August 18 | | 12:19 P M | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. list birt) | | | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIPT | HPLACE (State or Foreign | | | | | | | |
| | 215-23-1615 1\overline{X} M 2 \subseteq F \ 6 \qquad \text{Y} \\ 90. FACILITY NAME (if not institution, give street end number) | PS. MONTHS . | DAYS HOURS MIN. | Jan 16,19 | | ryland | | | | | | | |
| DIRECTOR | The Johns Hopkins Hospital | F | Baltimore | | None | | | | | | | | |
| E | 10e. STATE 10b. COUNTY 10 | c. CITY, TOWN | OR LOCATION | | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| ā | Maryland Howard | Elli | cott City | | | 1 TYES 2 NO | | | | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | 10f. ZIP CODE | | | WHAT COUNTRY? | | | | | | | |
| Ä | 4733 Bounty Court | | 21043 | | | d States | | | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | | WAS DECENDENT OF HISPAI It yes, specify Cuban, Mexico | en, Puerto Rican, atc.) | Sie | CE — American Indien, ck, White, etc. | | | | | | | |
| BY | 3 Widowed 4 Divorced IF YES, GIVE WAR OR DAYES | | 1 TYES 2 NO Specif | y: | Spe | White | | | | | | | |
| | 15. DECEDENT'S EDUCATION 16e. DECED | ENT'S USUAL O | CCUPATION | 16b. KIND OF BUS | INESS/INDUSTRY | 111200 | | | | | | | |
| COMPLETED | (Specify only highest grade completed) (Give killife. Do. Elementary/Secondary (0-12) College (1-4 or 5+) | NOT use retired.) | during most of working | | | | | | | | | | |
| MPI | 1 Stud | dent | | Non∈ | 2 | | | | | | | | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NA | AME (First, Middle, Malden : | Surneme) | | | | | | | | |
| BE | Jeffry J. Fedderly | | | M. Malcoln | | | | | | | | | |
| 2 | | | S (Street end Number or Rural | | | 1 7 01040 | | | | | | | |
| | Jeffry J. Fedderly 47. | | ty Court E | | CATION - City or | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | | | | | | | |
| | 1 Burlet 2 X Cremation 3 Removal from State cometery cremate | ory or other place. | | 1 | | 0.00000 | | | | | | | |
| | 21. SIONATURE OF FUNERAL SERVICE LICENSEE | | NAME AND ADDRESS OF FA | | iter, Ma | ryranu_ | | | | | | | |
| | + Sa a colli- | | Harry H. Wit: | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| z | ahock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Ceve his indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed of dying, such as earlies or respiratory arrest, and or death indeed or dying, such as earlies or respiratory arrest, and or death indeed or dying, such as earlies or respiratory arrest, and or death indeed or dying, such as earlies or respiratory arrest, and or death indeed or dying, such as earlies or respiratory arrest, and or dispiratory arrest, a | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Cliabetic Ketoacidesis Unional Ketoacidesis Due to (or as a consequence of): Due to (or as a consequence of): d. | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent conditions contributing to deeth but not resu | | | PERSON 1 YES 2 | MED? | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO | | | | | | | |
| ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH | | | N 🗆 | | | | | | | | | |
| CIA | EXAMINER? HOSPITAL: | F DEATN (Check | | | | | | | | | | | |
| YSI | 1 Topetlent 2 ER/Outpetlent 3 | DOA 4 II Nu | rsing Home 5 - Residence | | | | | | | | | | |
| ву Рн | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 8b. TIME OF INJURY M | 28c, INJURY AT WORK? 1 YES 2 NO | 26d. DEŞCRIBE HOW II | NJURY OCCURED | | | | | | | | |
| ETED B | 3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, building, stc. (Specify) | term, street, tac | ctory, office | 28t. LOCATION (Street (City or Town, State) | end Number or Burn | al Route Number, | | | | | | | |
| COMPLE | 29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death medical EXAMINER: On the best of axamination and/or inve | | | | | e(s) end menner ee stated. | | | | | | | |
| BE | 296. SIONATURE AND TITLE OF CERTIFIER L. Kyle Walker MD | | 29c. LICENSE NU | | . 1 | ED (Month, Day, Year) + 28 1995 | | | | | | | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) | T) (Type, Print) | 601 N. Wol | fe St R. | Himore | mel | | | | | | | |
| | 2. Kyle Walker 1510 Blaylee 31. DATE FILED (MONTH, Day, Year) AUG 2 8 1995 Julia dhamban handall | (| | | | | | | | | | | |

he hospital or attending physician. detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| . Page 6 may be retained by the hosp ral director, page 5 should be detached iner must be notified at once. | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| vither 24 hours after deat obstely filled in by the fun remation, or removal. | |
| certificate be executed voiling physician and comp Hygiene prior to burial, c | |
| v requires that the death been signed by the atter r. of Health and Merrial is shows any injury, o | |
| ING PHYSICIAN: The law After this certificate has leath with the State Dep marked, or item 23 | |
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4.7 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burla, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - FOR STATE REGISTRAR | STATE OF MA | RYLAND / | DEPAR | TMENT | OF H | IEALTH DE AT | AND I | MENT | AL HYGIEN | | | | |
|------------------|------------------------------------------------------------------------|-----------------------------------|------------------------------------|---------------------------|--------------|-------------|-----------------|---------------------------------------------------------------------------------|----------|--------------------|--------------|-----------------|------------------------------------|-------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) EDITH T. | | EDENCH | | | | | | MO | TE OF DEATH | AV | YEAR | 3. TIME OF DEA | TH |
| 150 | EDITH L. | | FRENCH | t historia d | IF UNDER | 1 VEAD | E INDEA | | | UST 19, | 1995 | | 3:46 | AM |
| | 218-18-9154 | 1 M 2 X F | 91 | YRS. | MONTHS | DAYS | IF UNDER | BAIN | (Mc | onth, Day, Year) | 104 | Countr | IPLACE (State or Fi y) KNOWN | oreign |
| | 9e. FACILITY NAME (If not institution, give | street and number) | 9b. CITY, TOWN OR LOCATION | | | | | | | 22, 19 | 9c. COUN | | | - |
| DIRECTOR | GARRETT COUNTY MI | EMORIAL HO | SPITAL | | | OAKL | AND | | | | RET | Г | | |
| JEC. | 10a. STATE 10b. COUNT | γ | 10c. CITY, TOWN OR LOCATION | | | | | | | | | | 10d. INSIDE CITY | , |
| | ALABAMA MARSI | IALL | BIG SPRING VALLE | | | | | | | | | | LIMITS? | NO |
| FUNERAL | 100. STREET AND NUMBER UNKNOWN | | | | | 101 | ZIP CODE | NOWN | | | 10g. CITIZ | | HAT COUNTRY? | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT E | VER IN U.S. ARI | WED | 13. | WAS DEC | | | | BIN? (Specify Yes | pr No. | USA 14. BACE | A — American Indi | 90 |
| BY F | 1 Never Married 2 Married 3 White No. W. Divorced | FORCES? 1 FYES, GIVE WAR | OR DATES | 0 | | li yea, sp | 2 NO | n, Maxica | n, Puert | o Rican, etc.) | | Black Speci | , White, etc. | ur, |
| | 15. DECEDENT'S EDI | UNKNOWN | | PENENT'S | USUAL O | CCUIDATIO | M | | | 6b. KIND OF BUS | 1 | IOTOM | MULIE | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Gh | ve kind of a Do NOT us | work done | during mo | st of working | 9 | 1 | es. KIND OF BUS | SINESS/INDU | JSIMT | | |
| MP | UNKNOWN | | | UNKN | OWN | | | | | UN | KNOWN | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | BOD | TME | | | 18. MOTH | | | t, Middle, Maiden | Surname) | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | | ADDRESS | S (Street a | nd Number | UNK | | mber, City or Town | a State 7in | Coriol | | |
| 2 | DENNETT ROAD MANO | R NURSING | | | | | | | | E – OAK | | | 21550 | |
| | 20a. METHOD OF DISPOSITION 1 □ Burial 2 ☒ Cremation 3 □ Rem | ioval from State | 20b. PLACE A | | | | me of | | | | CATION — C | | | |
| 1 | 4 Donation 6 Other (Specify) | CENSEE _ | OFIEGA | A CRI | - | | ID ADDRES | S OF FA | | | | | W VA | |
| - 1 | · fol All | 10 | MOO | 167 | | | | | | P. ME - OA | 0. BO | | | |
| _ | 23. PART i. Enter the diseases, or | complications that c | eused the dea | ith. Do r | | | | | | | | | Approxim | ate |
| | immediate or condition | | | | | | | | | | | | | etween d Death |
| | disease or condition resulting in death) | . Respira | tory failure AS A CONSEQUENCE OF): | | | | | | | | | | 5 da | ays |
| z | Chronic interstitial lung disease | | | | | | | | | | V | ^6 | | |
| TT 0 | Sequentially list conditions, if any, leading to immediate | | AS A CONSEO | | | unig | _ u / 5 (| cusc | | | | | J' | 3 |
| 5 | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | c. DUE TO (Of | AS A CONSEQ | UENCE OF | n: | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | , | | | | | | | | į | |
| AL C | PART II. Other algnificant condition | na contributing to de | ath but not re | suiting | in the un | derlying | cause d | iven in | Part i. | 24s, WAS AN | ALITOPSY | 7.4h | WERE AUTOPSY FI | MOIMOR |
| S | | | | | | | | | | PERFOR | MED? | | AVAILABLE PRIOR COMPLETION OF C | TO |
| PHYSICIAN: MEDIC | | | | | | | | | | | | | OF DEATH? | 10 |
| AN: | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAUS | | | | | XUNC | ERTAIN | 1 🗆 | | | | | |
| SICI | EXAMINER? | HOSPITAL: | 26. PLACE | | OTHER | R; | E D Bee | ddanaa | | her (Specify) | | | | |
| ¥ | 27. MANNER OF DEATH | 26a. DATE OF tN. (Month, Day, | JURY | 26b. TIM | | 26c. INJI | | HOUNCE | | EŞCRIBE HOW IN | JURY OCCI | JRED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | 110.00 | | | М | 1 🗌 Y | ES 2 🗌 | NO | | | | | | |
| COMPLETED | 3 Suicide 6 Could not be determined | 26a. PLACE OF II building, etc | NJURY — At hon . (Specify) | ne, ferm, a | treet, fact | ory, office | 1 | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | oute Number, | | |
| F | 29a. CERTIFIER 1 XCERTIFYING PHYS | ICIAN: To the best of my | knowledge, des | th occurre | ed et the ti | me, data | and place, | and due | to the c | ause(s) and man | ner as state | d. | | |
| NO. | One) 2 MEDICAL EXAMINE | R: On the basis of exam | ination and/or in | rvestigatio | n, in my o | pinion, de | eth occure | d at the | time, da | te and place, and | d due to the | cause(a) | and manner as st | lated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | R | | | - | | 29c. LICE | | | | | | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | OF DEATH STEM | 27) /5 | Print | | D33 | 3464 | | | ▶ 8/ | 19/9 | 95 | |
| | Robert Coughlin, | M.D. P (|) Box | 8 F | | . WV | 267 | 16 | | | | | | |
| | 31. DATE FILED (Month, Day, Your) AUG 2 5 1995 | 32. REGISTRAR'S | SIGNATURE | 7 | 31011 | 2 11 1 | 207. | 1.0 | _ | | | | | |
| | nuu 4 9 1995 | Alia Mude | ertartal | 6 | | | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

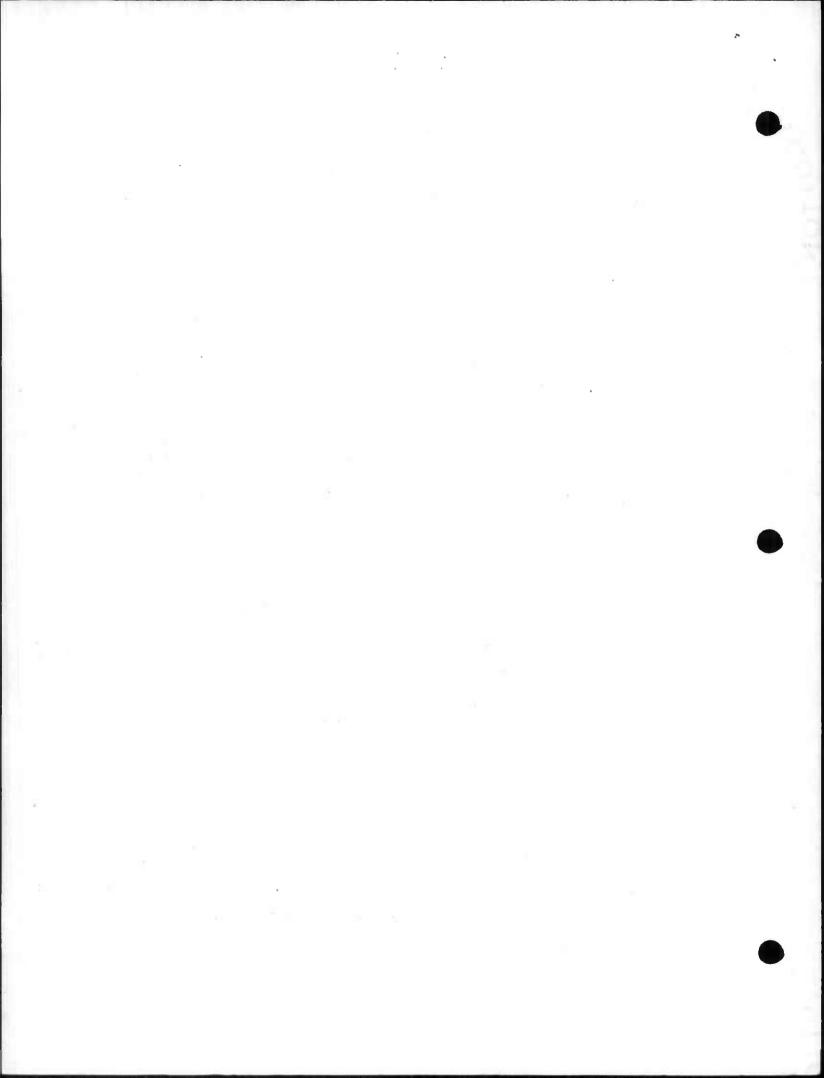
| | | | | | ICALE | | | | REG. NO. | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF | | | | 3. TIME OF DEATH |
| 1 | Char1 | otte Mo | oore | | | GR | AY | AUGU | E T DAY | - 1 | 993 | 2100 ·M |
| | 4. SOCIAL SECURITY NUMBER | | | | | | | | | 25) | | |
| | | | 6. AGE (In yra | s. last birthday) | IF UNDER 1 | | UNDER 24 HRS. | 7. DATE OF I | SIRTH | | BIRTH | PLACE (State or Foreign |
| 1 . | 220-28-1676 | 1 - M 2)(XF | 62 | YRS. | MONTHS | DAYS HO | URS MIN. | Month, De | ຶ່ງ 🐃 1 ດ | 32 | Countr | Maryland |
| | Sa. FACILITY NAME (If not institution, give a | tract and aumber) | | | | | | | 3,13 | | _ | |
| 00 | | | | | | | OCATION OF DE | EATH | - 1 | 9c. COUN | | |
| DIRECTOR | PENINSULA REGIONA | AL MEDICA | L CENT | EER | SA | LISBU | JRY | | - 1 | WI | COMI | CO |
| 15 | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| W. | 10a. STATE 10b. COUNTY | Υ | | 10c. CIT | Y, TOWN OR | LOCATION | | | | | T | 10d. INSIDE CITY |
| 쁜 | Maryland | Dorchest | tor | | Vie | | | | | | - 1 | LIMITS? |
| | | DOLCHESI | LEI | | уте. | iiiia | | | | | | XYES 2 NO |
| ₹ | 10s. STREET AND NUMBER | | | | | 101. ZIP | CODE | | | 10g. CITI2 | EN OF W | HAT COUNTRY? |
| FUNERAL | 209 Market St | reet | | | | | 218 | 69 | | | 1 | IS |
| ĮΞ | 11. MARITAL STATUS | 40 1100 000000000 | | | | | | | | | | |
| 교 | 1 Never Married X Married | 12. WAS DECEDENT FORCES? 1 | YES YES | ARMED | 13. W/ | S DECENDE | ENT OF HISPAN Cuban, Mexica | VIC ORIGIN? (S | pecify Yes | or No- | 14. RACE | - American Indian, White, etc. |
| | | IF YES, GIVE W | | | 1.5 | YES 2X | NO Specify | V. | 1, 466.7 | | | White |
| B | 3 Widowed 4 Divorced | l | | | | 25 | | | | - 1 | ор оз | , MILLLE |
| | 15. DECEDENT'S EDU | CATION | 16a | . DECEDENT'S | USUAL OCC | SIPATION | | 165 100 | D OF BUSI | NEGO (IND) | ICTOV | |
| E | (Specify only highest grade | completed) | | (Give kind of a | vork done dui | ing most of | working | 100. Kilk | D OF BUSI | NESS/IND | DSIRI | |
| " | Elementary/Secondary (0-12) | College (1-4 or 5+) |) | | | 0.1 | 1 | | 0 | | - | - |
| 윤 | 11 | | | Fis | cal | Cler | k | | St | ate | Emp | ployee |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. | MOTHER'S NA | ME (First Michael | e Majdan S | umamel | | |
| | Erville Moore | | | | | 1 | | | | | | |
| BE | | | | | | | | a Dav | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILINO | ADDRESS (S | Street and No | umber or Rural I | Route Number, C | ity or Town, | State, Zip | Code) | |
| Ρļ | Moody S. Gray | | | P.O. | Box | 205 | Vien | na M | arv1 | and | 218 | 260 |
| | | | 200 000 | | and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th | | | | | | | |
| - 3 | 20a, METHOD OF DISPOSITION 1) Derivation 2 Cremetion 3 Rem | oval from State | 20b. PLA | CE AND DATE | her place! | ON (Name of | , | DATE | 20c. LOC. | ATION — C | Ity or To | wn, State |
| | 4 Donation 5 Other (Specify) | | Dor | cheste | r Mem | orial | Park | 8/29 | Car | nbrid | lge. | Maryland |
| | 21. SIGNATURE PAFUNERAL SERVICE LIC | ENSEE | | | | | DORESS OF FA | | | | , | |
| | - /// - / | | | | Th | omas | Funera | 1 Home | P | Δ | | |
| | the us from | ~ | | | | | | | | | | and 21613 |
| | 23. PARTA. Enter the diseases, or o | complications that | named the | death De | 70 | O LOC | ust st | • Callib | TTUR | e, ric | II y I c | |
| | shock, or heart fellure. | Liet only one ceus | e on asch | line. | ot anter th | a moda o | aying, suci | n ss cardiac | or respire | etory arre | est, | Approximats interval Between |
| 1 | IMMEDIATE CAUSE (Final | | | | | | | | | | | Onset and Death |
| | disease or condition | s. ret | laghat | · · | 3000 | . 1 | | | | | | i |
| | resulting in death) | 8 | 00 10 1 00 | SEQUENCE OF | | / | Course Co | | | | | 3, 6, |
| | | | | ASERDENCE OF | ·): | | | | | | | |
| | | DUE TO (| | | | | | | | | | i |
| N | | b | | | | | | | | | | |
| NOIL | Sequantisity list conditions, | b | | NSEQUENCE OF | 7): | | | | | | | |
| ATION | Sequantisily list conditions, if any, leading to immediata cause. Enter UNDERLYING | b | | NSEQUENCE OF | 7): | | | | | | | |
| FICATION | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury | b. DUE TO (| OR AS A CON | | | | | | | | | |
| TIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO (| OR AS A CON | NSEQUENCE OF | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury | b. DUE TO (| OR AS A CON | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CON | NSEQUENCE OF | 7): | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b | OR AS A CON | NSEQUENCE OF | 7): | orlying cau | usa given in | Part I. 24e | . WAS AN A | | 246. | WERE AUTOPSY FINDINGS |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CON | NSEQUENCE OF | 7): | erlying cau | usa given in | | PERFORM | ED? | 246. | AVAILABLE PRIOR TO |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CON | NSEQUENCE OF | 7): | orlying cau | usa given in | | | ED? | | |
| MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (| OR AS A CON | ot rasulting I | n the unde | | | _ 10 | PERFORM | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (| OR AS A CON | ot rasulting I | n the unde | | | _ 10 | PERFORM | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTI | b. DUE TO (| OR AS A CON | ot rasulting I | n the unde | o DKU | | _ 10 | PERFORM | ED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a from the remained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the the funeral director, page 5 should be detached to be added to be a found to be a funeral death with the Case and the Case of March Universal Universal Angels (American Properties of Properties Case of American Angels (American Properties Case of Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Case of American Angels (American Properties Cas | De mouvaining bours are deau was use been, or regula an menta hybere provis definition, or manager must be natified at once. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical assembler must be natified at once. |
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last)

| | VICTORIA ANN | GERMAIN | Œ | | | AUGUST 2 | 1, 1995 | 2:59 P M |
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| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. Is | ** | R 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTI | NPLACE (State or Foreign |
| | 318-12-3857 | 1 □ M 2/□ F 76 | YRS. MONTHS | DAYS | HOURS MIN. | (Month, Day, Year) 11/24/18 | Count | MN |
| ~ | 9a. FACILITY NAME (If not institution, give street | · · | | | R LOCATION OF DE | ATN | 9c. COUNTY OF E | DEATH |
| DIRECTOR | Berlin Nursing | & Rehab. Cen | iter | Berl | lin | | Worce | ster |
| RE | 10a, STATE 10b, COUNTY | | 10c. CITY, TOWN | | | - | 10d. INSIDE CITY LIMITS? | |
| | MD MOI | ntgomery | Rock | kville | | | | 1 X YES 2 □ NO |
| FUNERAL | 880 Azaleia Dr. | | | 101. | 20850 | | 10g. CITIZEN OF 1 | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. A FDRCES? 1 YES 2X IF YES, GIVE WAR DR DATES | ND | If yes, spe | | IC DRIGIN? (Specify Yes , Puarto Rican, etc.) | Blac | E — American Indian, k, Whila, etc. h/y: White |
| ED | 15. DECEDENT'S EDUCA' (Specify only highest grade co | | ECEDENT'S USUAL C | OCCUPATIO | N. | 16b. KIND OF BUS | INESS/INDUSTRY | |
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| BE CC | John Joseph Franczak | ς | | | | ME (First, Middle, Melden Warwa | Surname) | |
| 5 | 19a, INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Town | n, State, Zip Code) | |
| П | George James Ge | | | | Casanov | | 017 | |
| | 1 ☐ Burtsl 2 XCremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) | al from State cometen co | ematory or other place | 1 | | DATE 20c. LO | Example for | |
| | 21. BIGHATUME OF PUNISHAL SURVICE LICEN | MEE CUD | | | D ADDRESS OF FAC | CILITY | | - V-3-2 |
| | 1/ Suh/ | Turale_ | | 108 | Williams | St. Berlin | ge Funer | al Home 1811 |
| | 23. PART Enter the diseases or con shock or heart failure. Lis | mplications that reused the d | leath. Do not enter | r the mod | de of dying, such | ss cardiec or respi | ratory srrest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final | | | |) 1 | 0 | | Onset and Death |
| | disesse or condition resulting in death) a. | Suire Se | equire | 1 | esord | a | | 3=mos |
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| 5 | Sequentially list conditions, if sny, leading to immediate | DUE TO (OR AS A CONSE | EQUENCE OF): | | 106 | - | 2072 | 1 2 |
| S | CAUSE (Disease or injury | DUE TO JOR AS A CONSE | | | Co | neusio | ж. | |
| MEDICAL CERTIFICATION | that initisted events resulting in death) LAST | DUE TO JOH AS A CONSE | (QUENCE OF): | | | | | i |
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| | Multiple & | ati Zlea | et Di | 40 | 20 | 7 La | | 1 ☐ YES 2 M NO |
| Ž I | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL/ | ACE DF DEATH (Che | | | |
| PHYSICIAN | 1 TYES 2 X ND | HOSPITAL: | 3 DOA 4- Nu | R: Irsing Nome | 5 🗆 Rasidence | ■ Other (Specify) | | |
| | 27. MANNER OF DEATN 1 X Natural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJU WOF | RK? | 28d. DESCRIBE NOW IF | JURY OCCURED | |
| BY | 2 Accident Investigation | 28s. PLACE OF INJURY At h | unme form etrael for | | ES 2 NO | 281, LOCATION (Street a | and Marines are Donated | 2 |
| 밀 | 4 Nomicide 6 Could not be determined | building, atc. (Specify) | orini, milit, mrage, rac | ctory, office | | City or Town, State) | nd Number or Hurai i | House Number, |
| COMPLET | 29a. CERTIFIER 1 X CERTIFYING PHYSICIA | AN: To the best of my knowledge, d | leath occurred at the | time, data | and place, and due | to the cause(a) and man | ner as stated. | |
| MO | One) 2 MEDICAL EXAMINER: | On the basis of examination and/or | Investigation, in my | opinion, de | eath occured at the t | time, data and place, and | d due to the cause(a | a) and manner as stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | P 00 1 | 2 - | | 29c. LICENSE NUM | BER | 29d. DATE SIGNED | (Month, Day, Year) |
| 10 B | sugario n. | Bellow ! | R.P. | | D29505 | | ► AUGUS | T 21, 1995 |
| | CDECODIO DELLCOC | | | T A OF | ODTOTT | EVD 100 C | 1017 | |
| 10 | GREGORIO BELLSOS, 31. DATE FILED (Month, Day, Voer) | M.D. 4421 BE | ECHWOOD P | LACE | , CKISFI | ELD, MD 2 | 1817 | |
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the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal.

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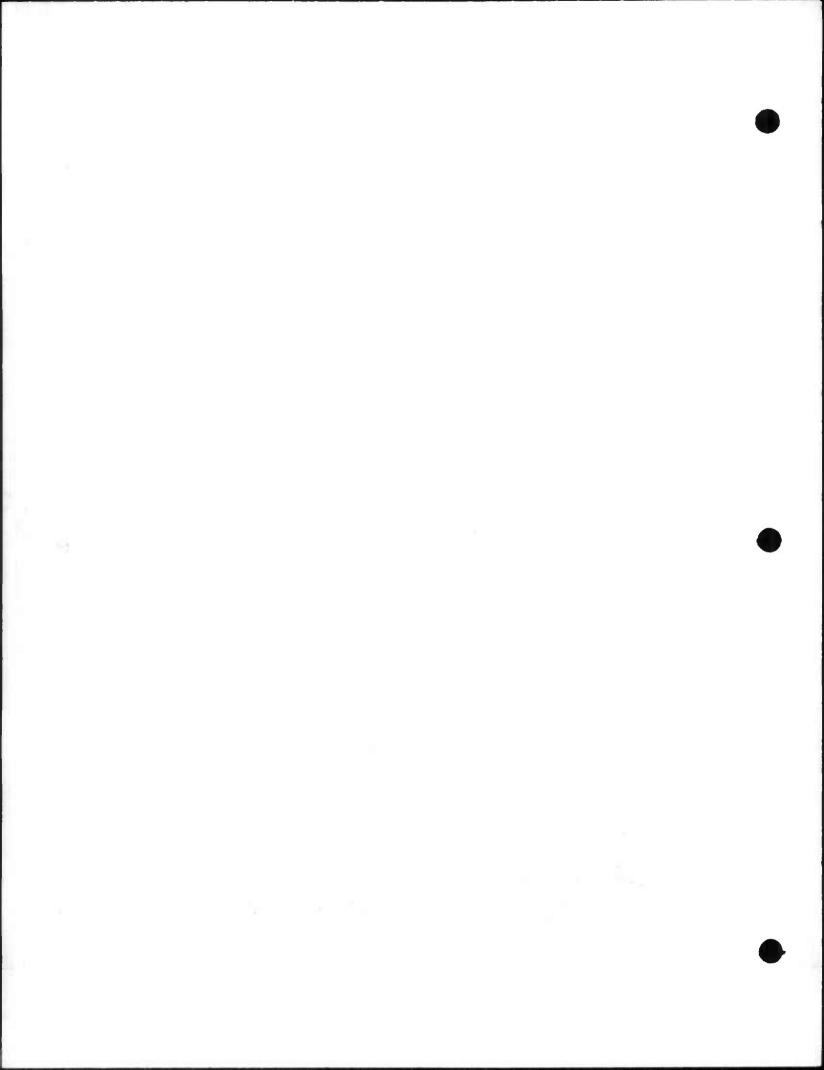
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permit.

FOR REGISTRAR 10a. STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Heim Helen July 1995 9:45 P M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 198-01-0751 1 🗌 M 2 🔀 F YRS. 85 01/03/10 Pennsylvania Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian - The Pines Talbot Easton 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Talbot Easton YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Rt. 50 & Dutchman's Lane 21601 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, atc.) BY 1 YES 2 NO Specify: Specify White 3 Wildowed 4 Divorced ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Щ College (1-4 or 5+) Elementary/Secondary (0-12) Own Home COMPL 12th Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Albert Charles Roller Amanda Norton Roller BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Amanda Morris 105 Liberty Rd., Federalsburg, MD 21632 20a, METHOD OF DISPOSITION
1 ※ Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE 4 Donation 5 Other (Specify) Valley Forge Gardens 31 King of Prussia, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY - Eskerv Michael Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death brovascular accident disease or condition reaulting in death) Lewsderosis CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES INO UNCERTAIN I 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occursed at the time, data and place, and due to the cause(e) and manner as stated, 29b. SIGNATURE TIE DE MITIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ion 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) lichaer Easton, MD 21601 Crow/ey, 31. DATE FILED (Month, Oak).
AUG - 1 95 32. REGISTRAR'S SIGNATURE a Davidson-Randall

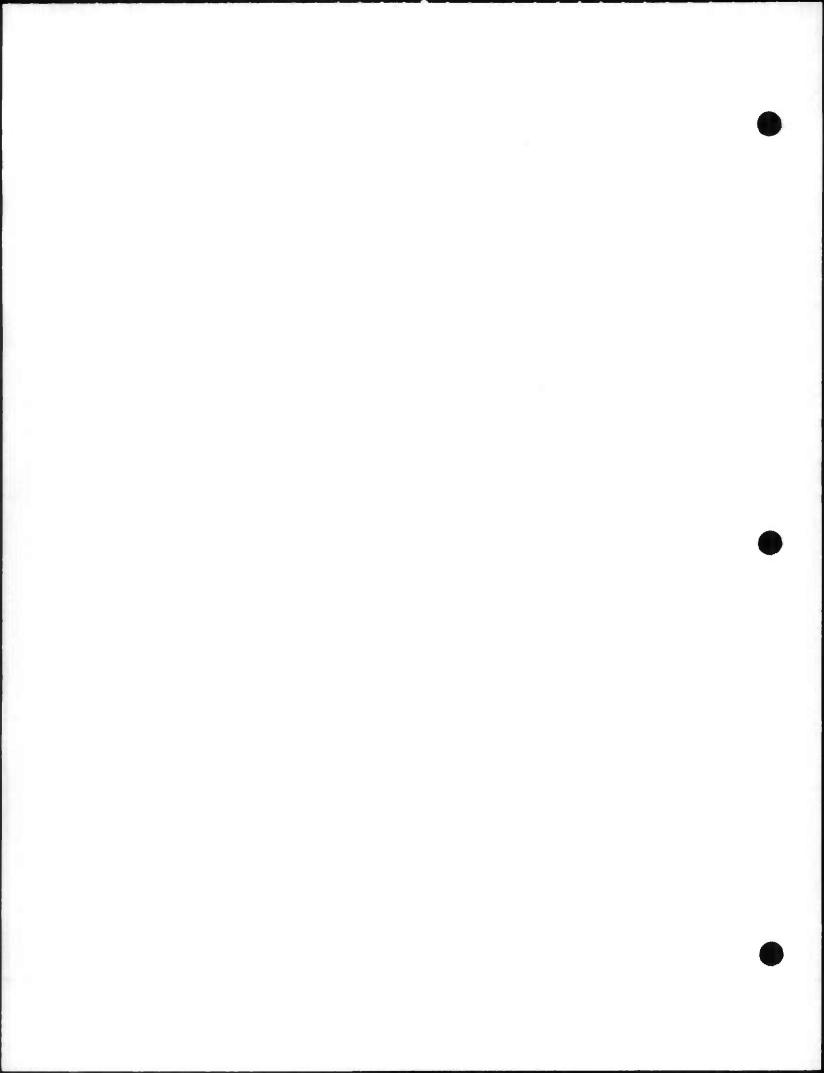


DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

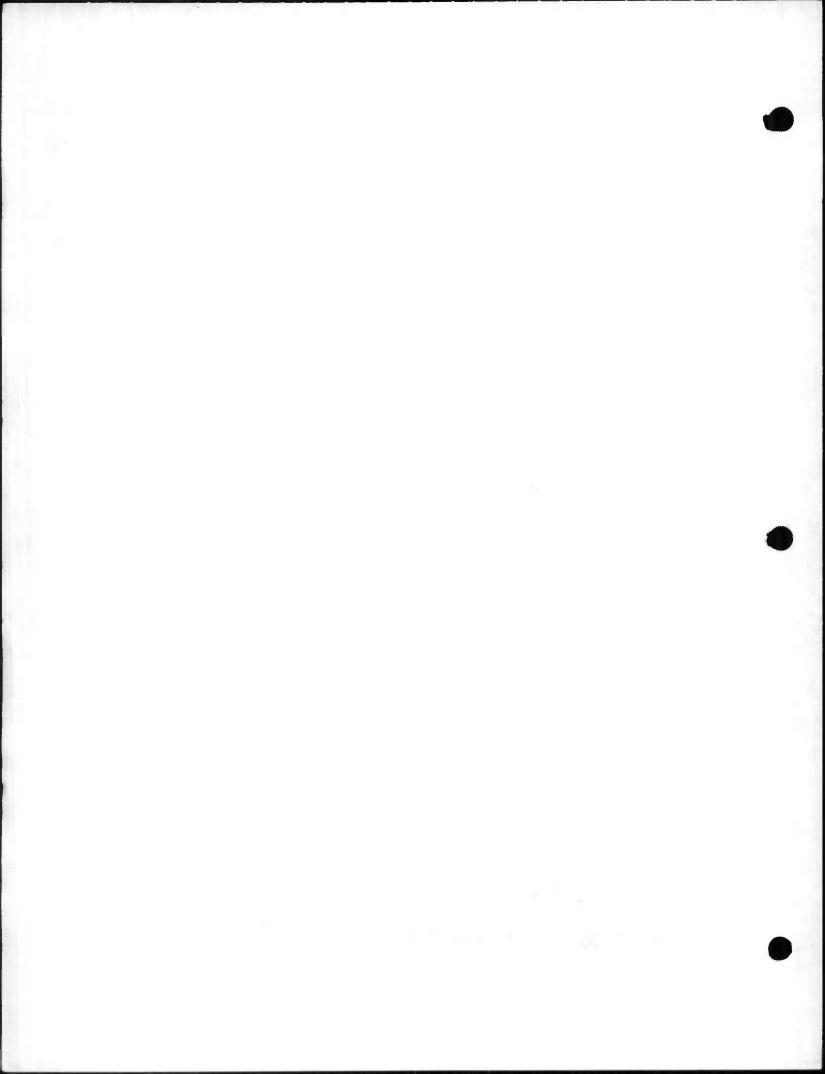
| | | | | | _ | OLI1 | 11110 | AIL | 01 | DLAI | | RE | G. NO. | | | |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|----------------------------|-------------------------|--------------------------|------------------------|---------|--------------------|------------|-------------------------------------|------------------------------|--------------|------------|--------------------------------------------------------------------------------|
| | | 1. DECEDENT'S NAME (First, | | my | Sad | die | Н | HALT. | ΔM | AN | | 2. DATE OF DE MONTH Aug. | EATH DA | 100 | 95 | 3. TIME OF DEATH |
| | 1 | 4. SOCIAL SECURITY NUMB | | 5. SEX | | in yrs. lest birti | | UNDER 1 Y | | IF UNDER | 24 MD0 | 7. DATE OF BI | | 19. | | 1:27 am |
| , | | 196-26-299 | | 1 □ M 2 F | G. 740.2 (r | 79 Y | *** | _ | AYS | HOURS | MIN. | October | 25, | 1915 | Count | PLACE (State or Foreign cyland |
| | . 1 | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 96 | b. CITY, TO | WN OF | R LOCATIO | N OF DE | ATH | | 9c. COU | NTY OF D | EATH |
| | | Memorial Ho | spital | | | | Easton | | | | | | Talbot | | | |
| H H |] يُ | 10e. STATE | 10b. COUNTY | 1 | | 10- | c. CITY, T | OWN OR L | OCATH | ON | | | | | | 10d. INSIDE CITY |
| | | Maryland 10. STREET AND NUMBER | Caro1 | ine | | | Den | ton | T | | | | | | | 1 YES 2 NO |
| 148 | | | | D - 1 | | | | | 101. | ZIP CODE | | | | 10g. CITI | | WHAT COUNTRY? |
| FLINER | | 11411 Green | sboro | KOACI | | | | | | 216 | | | | | | S.A. |
| × | | 1 Never Merried 2 3 Widowed 4 Divo | | FORCES? 1 | YES | 2 XNO | | If ye | s, spec | elfy Cubar 2 NO | 1, Mexicar | IC ORIGIN? (Spi n, Puerto Rican, | etc.) | or No— | Speci | — American Indian, i, White, etc. dy: Casian |
| 0 | | | EDENT'S EDUC | | | 16e, DECEDE | | | | | | 16b, KIND | OF BUS | INESS/IND | | astall |
| ET E | | Elementary/Secondary (0 | highest grade | College (1-4 or 5 | -) | (Give kir life. Do h | nd of work NOT use re | done durir stired.) | ng most | l of working | 9 | 20000000 | | | | |
| once. | | 11 HS grad. | | 3 | ' I | Reg | iste | red | Nur | cse | | | Med: | icial | L/Nu | rsing |
| once. | | 17. FATHER'S NAME (First, MI | iddle, Last) | | - | | | | | 18. MOTH | ER'S NAI | AE (First, Middle, | Melden S | Sumame) | | |
| 76 U | . 1 | Calvin | Frank | clin Hal | .tama | in | | | | | Sad | ie Amy | To | owers | 5 | |
| TO BE | - 11 | 190, INFORMANT'S NAME (7) | rpe/Print) | | | 19b. MA | ULINO AD | DRESS (St | reet an | d Number | or Rural A | oute Number, Cit | y or Town | , State, Zip | Code) | |
| ē F | | Lorraine Ta | | | | | | | | | | | | | | colina 2964 |
| 20 | | 20a, METHOD OF DISPOSITI 1-13 Burlel 2 □ Cremetio | ON Bom | numl from Chat- | | PLACE AND D | DATE OF D | ISPOSITIO | | | | | _ | ATION - | | |
| er must be | | 4 Donation 5 Other | (Specify) | Ami Mour State | - R | etery, cremator | y or other i | mete | ry | | | 8/5 | Rid | gely | Mai | ryland |
| Julia | | 21. SIGNATURE OF PUNERAL | L SERVICE LIC | ENSEE / | h | 0023 | - | 22. NAN | ME AND | ADDRES | | LITY | | | | |
| medical exam | 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases or complications that caused | | | | | ore | _ | PO | Dra | awer | B, 1 | Home, Denton, | Mai | rylar | nd 2: | 1629 |
| rital Hygiene prior to burlal, cremation, ry, or other traumatic event, the CERTIFICATION | | iMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| ijury, or o | | resulting in death) LAST | | 1 | | | | | | | | | | | | |
| of Health and Mental hows any Injury, MEDICAL CE | | PART II. Other significal | fit conditions | contributing to | death bu | ent not result | ting in th | he under | lying | cause g | iven in i | | WAS AN A PERFORM YES 2 | 11 | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | DID TOBACCO US | SE CONTE | PIRLITE TO CA | LISE OF | E DEATH | VEC | | | LINICI | EDTAIN | | | | | 1 YES 2 NO |
| d, or Item 23 sl | | 25. WAS CASE REFERRED TO | | IDOTE TO CA | | 8. PLACE OF | | | | OIACI | INIMIN | | | | | |
| State Item | | EXAMINER? | | HOSPITAL: | | | 01 | THER: | | | 70007 0 | | | | | |
| ed, or Item 23 s PHYSICIAN: | | 27. MANNER OF DEATH | | 26e. DATE OF | _ | | b. TIME OF | | : INJU | | idence (| 28d. DESCRIBE | | ILIBY OCC | HIBED | |
| s marked, | - 10 | | Pending restigation | (Month, D | ay, Year) | | INJURY | M 1 | WOR! | K? | NO | Zed. DESCRIBE | . NOW IN | JUNY OCC | OMED | |
| 28 is | | | Could not be letermined | 26e. PLACE O building, | F INJURY - etc. (Specif | — A1 home, fi | arm, atree | ot, factory, | office | | | 26f. LOCATION City or Town | (Street ar | nd Number | or Rural R | oute Number, |
| If item | | | | CIAN: To the best of | | | | | | | | | | | | |
| N S | 1 | | | R: On the besie of e | amination | end/or invest | tigation, in | ny opink | on, des | eth occure | d at the t | lme, data and p | lace, end | due to the | e ceuse(s) | and manner ee stated. |
| TO BE CON | | 296. SIGNATRINE AND TITLE | MI | Olle | - 17 | 20 | | | | 29c. LICE | S S | 28 4 | 1 | > < | \$ 2 | (Mogh, Day, Year) |
| | | AND/ | BA | AUG | PU | MD (ITEM 27) | (Type, Prin | 50 | 13 | X | 49 | 6 6 |)es | rf | me | n02162 |
| | | 31. DATE FILED (Month, Day, Y | bar) | 32. REGISTRA | | | | | | | | | | | | / |
| | | AUG - 4 '95 | | Tina Davido | son-A | anders. | | | | | | | | | | |



| BALTIMORE, MARYLAND 21215-0020 | 8 6 may be retained by the hospital or attending physician. | ector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | must be notified at once. |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIN | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MAR | YLAND / | DEPAR | RTMEN | OF H | EALTH | AND ! | MENTAL | HYGIEN REG. NO | | | | |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|---------------------|---------|------------|-------------------------|--------------------------------------|------------------------------------------------------------------------------|------------------|---------------|-----------------------------------------------------|----------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) Edward James Hes | | | | | | | | 2. DATE OF OEATH DAY YEAR 3. TIME OF | | | | 3. TIME OF DEATH | |
| | | 1 🔀 M 2 🗆 F | GE (In yrs. less | t birthdwy) YRS. | IF UNDER | DAYS | IF UNDER | 24 HRS. MIN. | 7 DATE C | OF BIRTH | 1922 | 8. BIRTH | IPLACE (Store or Form | |
| TOR | 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | | | | |
| - DIRECTOR | Maryland Caroline | | | 10c. CITY, TOWN OR LOCATION Greensboro | | | | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 N | 10 |
| FUNERAL | 462 Dutchmans Lane Apt 32 | | | | 101. ZIP CODE 21639 | | | | | | A. | VHAT COUNTRY? | | |
| В | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced 12. WAS OCCEDENT EYER IN U.S. AR FORCES? 1 YES 2 IF IF YES, GIVE WAR OR DATES | | | | | | | | | in, Puerto Rican, etc.) Bis | | | — American Indiar c, White, atc. "y: White | k _g |
| COMPLETED | 15. GECEGENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | | | Merkle Printing/ commen | | | | | mer | |
| BE CO | 17. FATHER'S NAME (First, Middle, Lest) Edward J. Hester 18. MOTHER'S NAME (First, Middle, Melden Surname) Gertrude Shuck Hester | | | | | | | | | | | | | |
| 10 | 196. INFORMANT'S NAME (Type/Print) Michael Hester 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8160 Arch Drive Denton, Maryland 21629 | | | | | | | | | | | | | |
| | 20e, METNOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remon 4 Donation 8 Other (Specify) | | 20b. PLACE A cometery, crer Che I | nd date | am V | eter | an's | | 8/7 | | cation – lten | | wn, Stete Marylan | d |
| | 21. SIGNATURE OF PURITAL SERVICE LICE | 1 For | lug | 1- | F | leeg | Box | elfe 160 | nbei | n Fune | . Ma | rv1a | | 9 |
| | 23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) | FATAL | n each line. | 2011 | not enter | the mod | de of dyl | ng, such | y hi | ac or reapl | ratory arr | reat, | Approximation Interval Bell Onset and | a ween |
| PHYSICIAN: MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | | |
| | PART II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 1 □ YES 2 XNO | | | | | | | | 24b. | WERE AUTOPSY FINI AMAILABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 YES 2 NO | USE | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | | | | | | |
| D 2 Accident Investigation M 1 YES 2 NO | | | | | | | JURY OC | CURED | | | | | | |
| | | | | | | | or Rural A | oute Number, | | | | | | |
| COMPLETED | 29s. CERTIFIER (Check only one) 1 CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Dey, Year) 440058 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |
| Henry DiTommaso P.O. Box 660 Denton, Maryland 21629 | | | | | | | | | | | | | | |

32 AEGISTRATIS SIGNATURE PAndelle



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—5 hours after death. Page 6 may be retained by the hospital or attending physician.

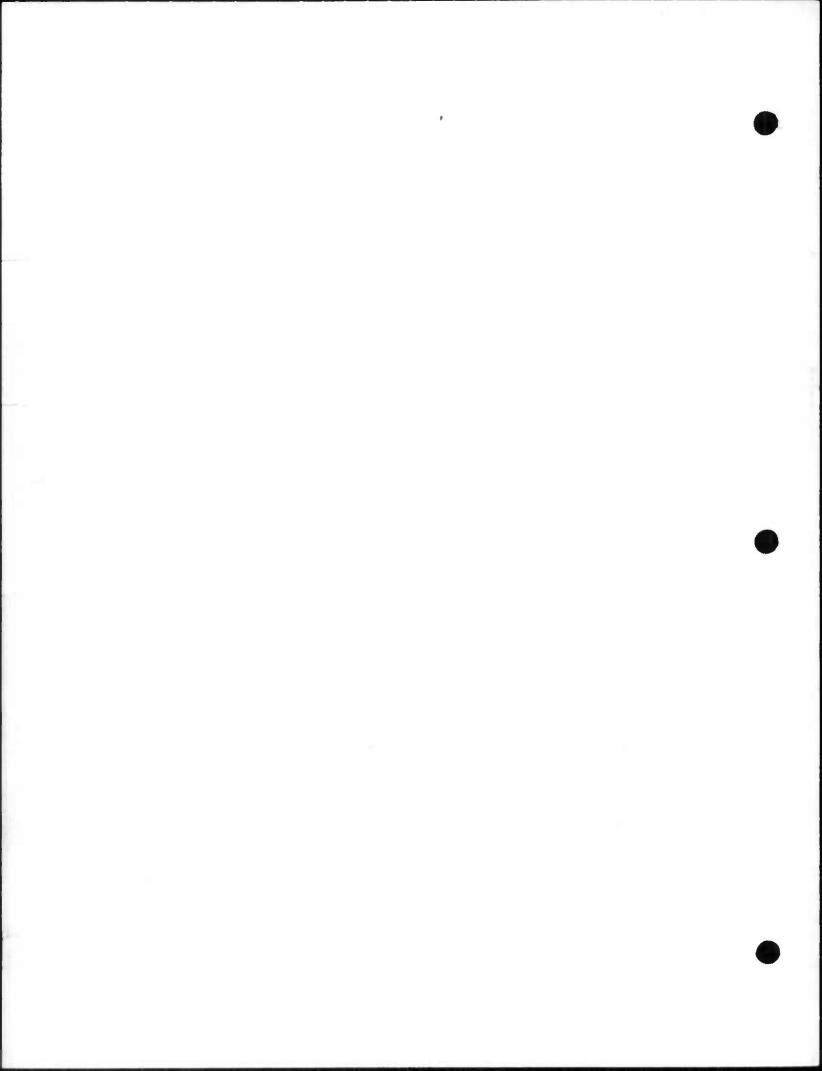
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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1 - STATE

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| | 1. DECEDENT'S NAME (First, Middle, Last) Mary B. | rd | | | 2. DATE OF DEA | 3. TIME OF DEATH | | | | |
| | Mary B. 4. SOCIAL SECURITY NUMBER | Hubba: | E (In yrs. last birthday) | | I | August | | 1995 8:40 A M | | |
| | 213-22-4867 | 1 🗆 M 2 💢 F | 89 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRT (Month, Day, V | 0 5 | 6. BIRTHPLACE (State or Foreign Country) Maryland | | |
| ا س | Sa. FACILITY NAME (If not institution, give a | | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | 9c. COL | 9c. COUNTY OF DEATH | | |
| DIRECTOR | Meridian - The | Easton | | | T | Talbot | | | | |
| | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | |
| | Maryland Ca | | | Pres | ton | | 1 YES 2 NO | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | TIZEN OF WHAT COUNTRY? | | |
| NE | 4461 Harmon | | 2165 | | | ted States | | | | |
| 国 | 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES | | | | CENDENT OF HISPA pecify Cuban, Maxico | in, Puerto Rican, el | | 14. RACE — American Indian, Black, White, etc. | | |
| ΒY | 3 🔀 Widowed 4 🗌 Divorced | II. YES, GIVE WAR OF | DATES | 1 1 1 | \$ 2 XNO Specif | у: | | Specify: Black | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DECEDENT'S (Give kind of | work done during n | ION lost of working | 16b, KIND (| F BUSINESS/IN | DUSTRY | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT u | estic | retired.) | | | | | |
| NO N | Second 17. FATHER'S NAME (First, Middle, Last) | 03010 | 18. MOTHER'S NAME (First, Middle, Maiden Surneme) | | | | | | | |
| BE C | 7/55 | Spencer H | Brown | | | garet E | | | | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) | | | | DRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| F | Ivory Corsey | | 4461 | Harmo | ny Rd., | Presto | on, MD | 21655 | | |
| W | 20a. METHOD OF DISPOSITION 1 Separate 2 Commetter 3 Remote 4 Donatton 6 Other (Specify) | ovel from State | tob. PLACE AND DATE of | ther place! | OSITION/Name of DATE 20c. LOCATION — City or Town, State Ch Cemetery 9-1 Goldsboro, MD | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Union C | 22. NAME / | ND ADDRESS OF FA | CILITY | | | | |
| | Muchail 7. | Eskew | | Fram PO B | ptom-Ha | wkins-E Federal | skow | Funeral Home | | |
| | PO Box 43, Federalsburg, MD 21632 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | |
| | resulting in death) - a. 2-3 down | | | | | | | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 9 | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | AS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | |
| | | | | ES 2 NO | COMPLETION OF CAUSE OF DEATH? | | | | | |
| Σ | DID TOPACCO LICE COATT | NOUTE TO GALLET | 0.5.00 | | | | | 1 TES 2 NO | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one) | | | | | | | | |
| SICI | EXAMINER? 1 VES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| Ě | 27. MANNER OF DEATH | 28a. DATE OF INJUR | Y 28b. TIM | E OF 28c. IN | JURY AT | 28d. DESCRIBE | | CURED | | |
| BY F | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year | , INJ | | YES 2 NO | | | | | |
| | 3 Suicide 8 Could not be determined | 28e, PLACE OF INJU- building, atc. (S) | RY — At home, ferm, a pecify) | street, factory, offi | ory, office 28t, LOCATION (Str. City or Town, S | | | reet and Number or Rural Route Number, tate) | | |
| щ | No. CONTRICTA | | | | | | | | | |
| SOMPLETED | (Check offy The CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. | | | | | | | | | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARVIN HEINDEL YEAR 11:00 R 1995 August A SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR & BIRTHPLACE (State or Foreign Country) Carroll IF UNDER 24 HRS. 212-18-5654 1 X M 2 - F 79 November use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2328 Golf View Lane DIRECTOR Hampstead Carroll RESIDENCE OF DECEDENT 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Adams New Oxford 1 TES 2 NO PA FUNERAL 10g. CITIZEN OF WHAT COUNTRY? IN 7IP CODE 19 Christopher Court, Hampton Plains 17350 USA retained by the hospital or attending physician. 5 should be detached for use as the burial-tran: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Marri 1 TES 2 NO Specify: ВҮ 3 Widowed 4 Divorced White ED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest gre COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 8 Welder Auto Body Repair 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) John H. Heindel Ti Lydia V. Frank BE notified director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Barbara A. Price 2328 Golf View Lane. Hampstead, MD hours after death. Page 6 may be pe 29s. METHOD OF DISPOSITION
1- Buriel 2 Cremetion 3 M. Removal from State
4 Donation 8 Dither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE must Glen Rock, PA 17327 Steltz eltz Cem Aug 31 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEI funeral Geiple Funeral Home, Inc. 17327 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. n by the removal. medical filled in by t Approximate ŏ IMMEDIATE CAUSE (Final **Onset and Death** cremation, event, the disease or condition renal 99 Cancer completely within resulting in death) DUE TO (OR AS A CONSEQUENCE OF): executed burial. rena tailur traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician are if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST 0 requires that the death has been signed by the atter Dept. of Health and Mental PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 NO OF DEATH? Shows 1 | YES 2 | NO The law PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) tem this certificate State HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: ATTENDING PHYSICIAN: 1 YES 2 ND 4 - Nursing Home 5 Residence 6 - Other (Specify) the 6 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, MIL 1 Natural 2 Accident 1 YES 2 ND DIRECTOR: After the hours after death item 28 is man death 84 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9 8 Could not be 4 Homicide Ш SH. COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. HOSPITAL FUNERAL within 72 h MPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 王분 mD0236 > August 29, 1995 223 9 30. NAME AND ADDRESS OF SON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) hlan Hunover Λ M. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

296. SIGNATURE AND TITLE OF CENTIFIER

Guy Fiscus,

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED DAUSE OF DEATH (ITEM 27) (Type, Print,

32. REGISTRAR'S SIGNATURE Jalia Stwelson Rardall

M.D.

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | OCCUTAL OD ATTENDIAL DUVELCIAN. The fear manifest that the death confidence he assessed within 28 house |
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Waneta 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR MONTHS DAYS HOURS Select. 218-12-5514 1 M 2 W F YRS. 88 Van. 28, 1907 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Deulin Manor Nursing Home permit. Pages 1, 2, 3 CUMBERLOND RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Allegany Maryland Cumberland FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE Bedford Road, N.E. completely filled in by the funeral director, page 5 should be detached for use as the burial-transit rial, cremation, or removal. 12412 21502 after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) Home maker 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) VOHN Bucklew notified at Laura BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Has7 Rd, N.E. Norman 12412 BedFord å 20a. METHOD OF DISPOSITION

1 M Burial 2 Cremetton 3 Re
4 Donation 5 Other (Specify) S DATE 20b. PLACE AND DATE OF DISPOSITION (Name of must Mul COMETORY medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ernest Leasure-Stein, Inc. 230 Baltimore Avenue a. Riley, (h Cumberland, Md. 21502 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF): and com o burial, o CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene ref if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF) the attending p that initiated events reaulting in death) LAST 23 shows any injury, PART II. Other algorithment conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? a de signed t 1 YES 2 NO been t, of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN IN PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 28. PLACE OF DEATH (Check only one) or item certificate I HOSPITAL 1 Inpetient 2 ER/Outpetient 3 DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this (is marked. Natural 5 Pending Investigation M 1 YES 2 NO After ti death BY 2 Accident 28e. PLACE DF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: hours after of 28 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: It item 2 29a. CERTIFIER CENTIFYING PHYSICIAN. To the best of my dgs, death occurred at the time, date and place, and due to the cause(s) and manner as stated, MEDICAL EXAMINER: On the be investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

CERTIFICATE OF DEATH

95 27433 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH MONTH Aug, 3. TIME OF DEATH YEAR 3:45 27 1995 8. BIRTHPLACE (State or Foreign Country) West Virginia 9c. COUNTY OF DEATH Allegany 10d. INSIDE CITY 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY HOME HardesT 21502 Cumberland, 20c. LOCATION - City or Town, State Cumberland, Marylow Approximata Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

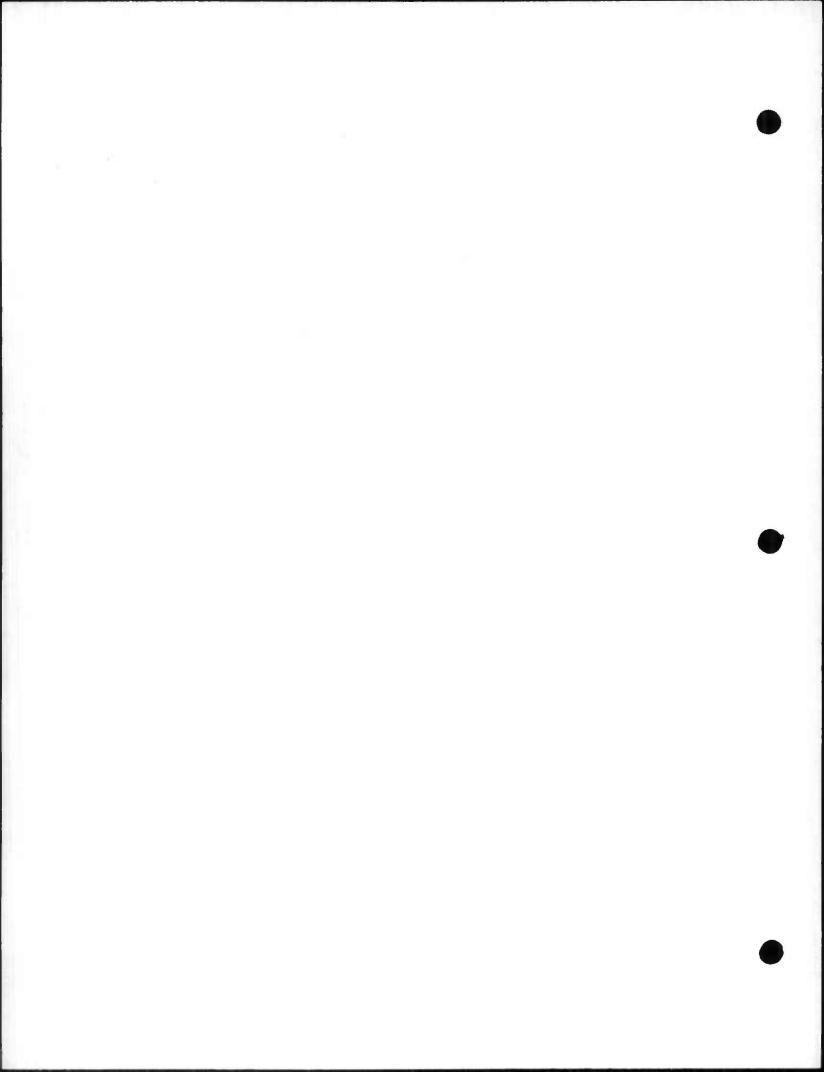
1 YES 2 NO

29d. DATE SIGNED (MONTH) Day No.

LICENSE NUMBER

500 Memorial Ave. Cumberland, Md. 21502

COMPLETION OF CAUSE



8:35

MD

10g. CITIZEN OF WHAT COUNTRY?

Specific

8. BIRTHPLACE (State or Foreign

YEAR

995

9c. COUNTY OF OEATH

ALLEGANY

USA

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

white

YES 2 NO

Approximate Interval Between

20 Min.

5 Years

10 Years

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO

1 YES ZO NO

281. LOCATION (Street and Number or Flural Floute Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

August 22, 1995

COMPLETION OF CAUSE

Onset and Death

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| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comp. | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comp be filed within 72 hours after death with the State Dept, or Health and Memtal Hygiene prior to burfal, co |

2. DATE OF DEATN BARBARA HUFFAKER **JEAN** AUGUST 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year Jul. 29, IF UNDER 1 YEAR DAYE HOURS 1 M 2 X F 218-60-1326 YRS. 1954 ter death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should Da. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Allegany Cumberland FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 510 City View Terrace 21502 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.)
 T YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 1 Never Married 2 Married ВУ 3 Widowed 4 N Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Health Room Tech Frederick Co. School System 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Sumi 16 Steven W. Gallagher Martha Alice McRobie BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Johnna P. Thomas 5 N. Front Street; Cumberland, MD pe 20a. METNOD OF DISPOSITION

T Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must cometery, cremetory or other place)
Elk Garden Cemetery 4 Donation 5 Other (Specify) 08/24 Elk Garden, WV examiner FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 24 hours after death. Scarpelli Funeral Home Cumberland, MD completely filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition Ventricular Fibrillation resulting in death) other traumatic event, DUE TO (OR AS A CONSEDUENCE OF): burial, Possible Coronary Heart Disease CERTIFICATION and Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE DE): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING aftending physician certificate be Hypertension CAUSE (Disease or injury DUE TO (OR AS A CONSEDUENCE OF) that initiated events resulting in death) LAST 0 injury, the PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the any requires that 1 YES 2 | NO shows : PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A Dept. 23 has t 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATN (Check only one) State HOSPITAL:
14 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO 4 - Nursing Nome 5 - Residence 6 - Other (Specify) the 9 28a. DATE OF INJURY 27. MANNER OF DEATH this c marked, 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Netural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

29s. CERTIFIER

1 CERTIFYING PHYSICIAN: To this best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

M.D .

2 MEDICAL EXAMINER: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated.

21556

29c. LICENSE NUMBER

D 23334

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED-CAUSE OF DEATH (ITEM 27) (Type, Print) DINESH SHAH M.D., P.O. BOX 131, PINTO, MD 32 AEGISTRAR'S SIGNATURE

29b. SIGNATURE AND TITLE OF CERTIFIER

6 Could not be

3 Suicide

4 Homicide

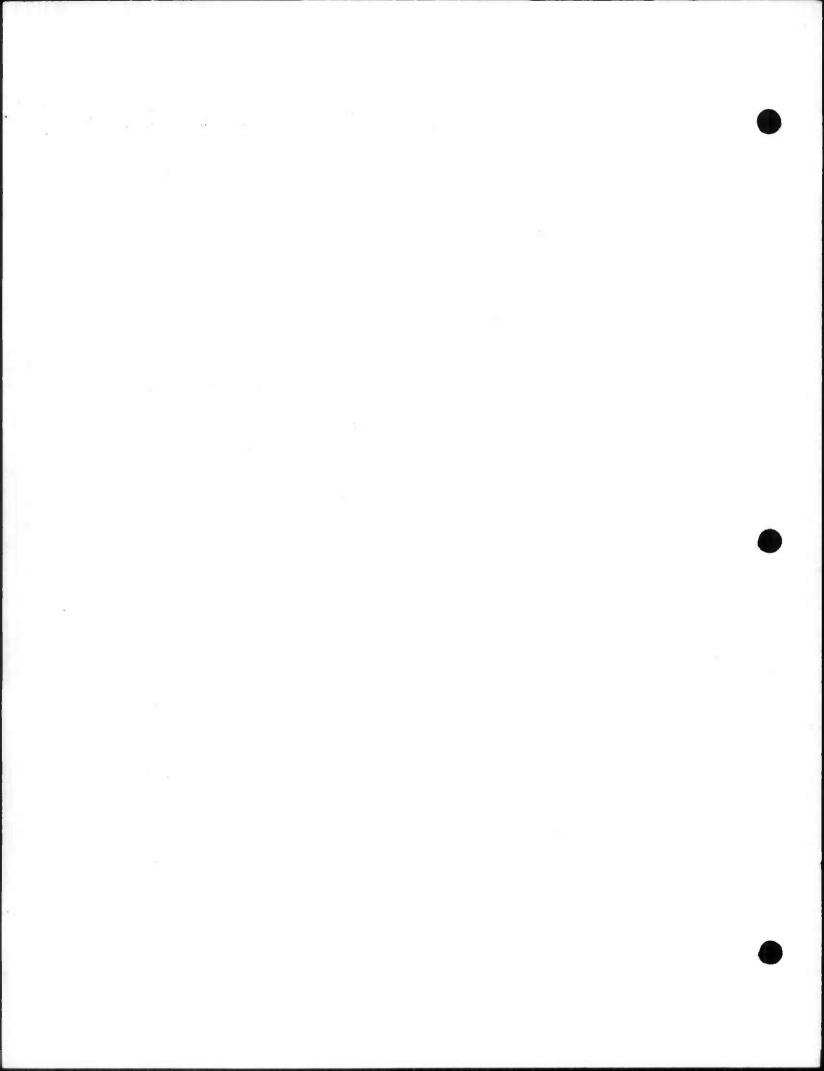
COMPLETED

BE

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DHMH-16 Rev 1/89



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

TO BE COMPLETED BY FUNERAL DIRECTOR

ITEMS: 23 PART I, 28a-f, PER MEO FILM G-729 11/20/95 t.t

ITEMS: 23 PART 1, 27, PER MEO FILM G-727 9/16/95 t.t

| AMENDED | #9C., | 8/14/95, | B.P., | WORCESTER | CO |
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| FOR | | STATE OF M | AARVI AND | / DEDADTMENT | OF |

| 1 - STATE REGISTRAR | | STATE OF MAI | | | OF HEALTH AND | MENT | AL HYGIEN | E | | | |
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| 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | | 2. DAT | E OF DEATH | | 3. | TIME OF DEATH | |
| NANCY | | R. | INS | LEY | | AUG | SUST O | 9 199 | EAR 5 | 1:00 | R |
| 4. SOCIAL SECURITY NUMB | BER | | AGE (In yrs. last birthday |) IF UNDER | 1 YEAR IF UNDER 24 HRS. | 7. DAT | E OF BIRTH | | | ACE (State or Foreig | - |
| 217-88-0513 | | 1 M 2 X F | 32 YRS. | MONTHS | DAYS HOURS MIN. | 01/ | nh, Day, Year) 06/1963 | | Country) | | |
| 9e. FACILITY NAME (If not in | | , | | | , TOWN OR LOCATION OF D | EATH | | 9c. COUNTY | | | |
| PENINSULA RESIDENCE OF DEC | | ONAL CEN | | | ISBURY | - | | SOME | | TWICOMI | Co |
| | | | | | OR LOCATION | | | | 10 | d. INSIDE CITY LIMITS? | |
| Maryland 100. STREET AND NUMBER | Somers | sec | Pr. | inces | s Anne | | | | | ☐ YES 2 🔣 NO | |
| 33742 Perry | Hawkir | n Road | | | 21853 | | | 10g. CITIZEI | OF WHA | T COUNTRY? | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EV | ER IN U.S. ARMED | 13. | WAS DECENDENT OF NISPA | NIC ORIG | IN? (Specify Yes | or No- 14 | BACE - | American Indian | - |
| 1 Never Merried 2 | | FORCES? 1 | | - 1 | If yes, specify Cuben, Mexic 1 YES 2 NO Speci | en, Puerto | Rican, etc.) | | Black, W Specify: | /hite, etc. | - 1 |
| 3 Widowed 4 Divo | EDENT'S EDUC | ATION | Ma DECEDENT | | | | | | V | White | |
| (Specify only Elementary/Secondary (0 | y highest grade o | College (1-4 or 5+) | 16a. DECEDENT (Give kind o | work done use retired.) | during most of working | 16 | b. KIND OF BUS | SINESS/INDUS | TRY | | |
| 12 | | 4 | Sonogra | n Tec | hnician | P | R.M.C. | | | | - 1 |
| 17. FATNER'S NAME (First, Mi | iddle, Last) | | | | 18. MOTNER'S NA | | | | - | | \neg |
| James W. Gr | cay | | | | Mary C. | Petr | | | | | - 1 |
| 190. INFORMANT'S NAME (7) | ype/Print) | | 19b. MAILIN | G ADDRESS | (Street end Number or Rural | | | n, State, Zip Co | ide) | | \neg |
| A. Wesley Ir | nsley | | 33742 | Perr | y Hawkin Rd. | . Pi | rincess | Anne. | Md. | 21853 | |
| 20a, METNOD OF DISPOSITI 1 X Burtal 2 Crematio 4 Donation 5 Other | n 3 🗆 Remo | val from State | 20b. PLACE AND DAT | E OF OISPOS | | DA | TE 20c. LO | CATION — City | or Town, | State | |
| 21, SIGNATURE OF FUNERAL | | NSEE | TITSC Day | | | D/ I | 13 Poco | moke C | ity, | Ma. | |
| · Sun | des. | mulsas | | | PLAND ADDRESS OF FACE SCOMORE City | | | | 54, | | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

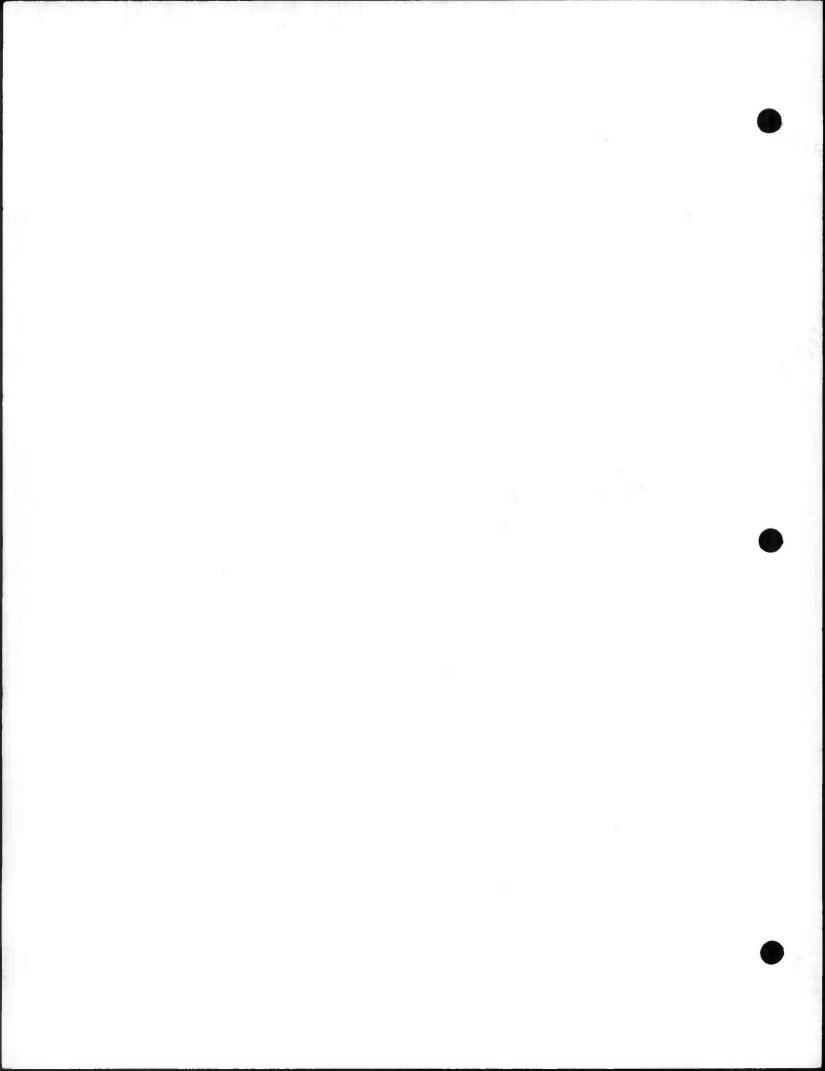
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE BEGISTBAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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| | | DOROTHY | | | JONE | - | | Aug. 6 | 199 | | 5:00 p M |
| | 4. SOCIAL SECURITY NUMBER 214-36-6128 | | 6. AGE (in yrs. last | | IF UNDER 1 YEAR | | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH | IPLACE (State or Foreign |
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| ā | Maryland Don | chester | | | | H | lur1c | ock | | - 1 | LIMITS? 1 YES 2 7 NO |
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| E | 5001 V | Villiams | burg (| hur | ch Rd | | 216 | 343 | Uni | ted | States |
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| BY | 1 Never Married 25 Married 3 Widowed 4 Divorced | IF YES, GIVE WA | | | | ES 27 NO | | Puerto Hican, atc.) | | Speci | |
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| | (Specify only highest grade Elementary/Secondary (0-12) | completed) | (GA | re kind of v Do NOT us | vork done during retired.) | most of working | ng | 16b. KIND OF BUS | BINESS/INC | DUSTRY | |
| PL | 12 + | College (1-4 or 5+) | | | r's A: | | | Edu | cati | lon | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | | | 18. MOT | HER'S NAME | E (First, Middle, Maiden | Sumamal | | |
| BE C | Johr | Thomas | Austi | n | | На | ttie | Bryant | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | 196 | MAILING | ADDRESS (Street | t and Number | r or Rural Ro | ute Number, City or Town | n, State, Zij | o Code) 🤈 | 16/13 |
| ۲ | Robert L. Jones | s, Sr. | 5 | 001 | Will: | amsb | ourg | Ch. Rd. | , Hu | ırlö | ck, MD |
| | 20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo | val from State | 20b. PLACE A cemetery, crem | NO DATE (| F DISPOSITION | Name of | | DATE 20c. LO | CATION - | City or To | wn, State |
| 1 | 4 Donation 5 Other (Specify) | | Feder | a1 | <u> Hill (</u> | | | | era1 | sbu | rg, MD |
| | 21. SIGNATURE OF EUNERAL SERVICE LIC | ENSEE / | | | | AND ADDRE | | LITY | | | |
| | Muhay 1. | Spori | 2 | | | | | deralsb | | | eral Home |
| | 23. PART i. Enter the diseases, or c | omplications that | caused the dea | th. Do n | ot enter the r | nods of dy | ing, such | ss cardiac or respi | ratory an | rest, | Approximate |
| | shock, or heart failure. I IMMEDIATE CAUSE (Finel | .int only one caus | e on each line. | | 1 / | | 1 | | | | Interval Between Doset and Death |
| | disease or condition resulting in death) | Word | 10 res | uras | han ti | ve. | 1 | | | | 301 |
| | | DUE TO (| OR AS A CONSEC | UENOE DE | D: 6 | + | 0.4.1 | ^ | | | 1 |
| S I | Sequentially list conditions, | 15/ | OR AS A CONSECU | fli | /Lev | note | 1011 | per | Nem | | 4ns |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | 1 | us venu | | The con- | 1 | | 1 | | | |
| 임 | CAUSE (Disease or injury that initiated events | | OR AS A CONSEQ | - | - ruen | then | | | | | - |
| E | resulting in death) LAST | | | | , | | | | | | İ |
| | | • | | | | | | | | | |
| EDICAL | PART II. Other aignificent conditions | contributing to d | eath but not re | sulting i | n the underly | ng cause s | given in Pa | ert I. 24s. WAS AN I | | 246. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| 8 | - My Story | tent | PUTOLA | عرب | say | - 1 | | 1 U YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? |
| Σ | ravere mel | letes / | Keel | 4 | Clar | ruples | yen | - / | | | I - YES 2 - NO |
| ÿ I | DID TOBACCO USE CONTR | IBUTE TO PAU | | | | | ÉRTAIN | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | T | OTHER: | 40. | | | | | |
| <u>₹</u> | 1 YES 2 160 | 1 (Monpatient 2 (1)) | | 26b, TIME | | eme 5 C Re | | Other (Specify) | | | |
| | 1 Natural 5 Pending | (Month, Dey | | 1943 | JIRY Y | YES 2 | | ad. DESCRIBE HOW IN | DUNY OC | CURED | |
| ĕ I | 2 Accident Investigation 3 Suicide . Count out to | 28e. PLACE OF | INJUNY — At hor | e, tarm, s | | | _ | Bf. LOCATION (Street a | not Microbia | or Board B | tude Mumber |
| | 4 Homicide S Could not be determined | building, et | tt. (Specify) | | | | 1 | City or Ewn, State) | | D 700 7 | tone Humber, |
| COMPLETED | 29a. CERTIFIER | IAN: To the best of o | no branchada a das | | | | | | | | |
| ₹ I | (Check only one) 2 MEDICAL EXAMINER | | | | | | | | | | |
| - 11 | 296. SIGNATURE AND TITLE OF CERTIFIER | 4.0 | | | | | | | | | |
| BE | White In | dON | 20 | | | 29c, LICE | ENSE NUMBI | ER | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE | OF DEATH (ITEM | 27) (Type | Print) | N | 0/ | 07 | 0 | 101 | 70 |
| | William H. Wo | | | | | ewile | d Av | e. Rast | on. | MD | 21601 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | | , 50 | - 141 | - " - 1 | - VIA | c., Last | ,011, | 110 | 21001 |
| | AUG - 8 '95 | 0 | Isan Band | | | | | | | | |
| الـــــــــــــــــــــــــــــــــــــ | - HIV - 0 - JJ | TIMO NIGH | they they | .00 | | | | | | | |



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

| STATE | 0F | MARYLAND / DEPARTMEN | r OF | HEALTH / | AND | MENTAL | HYGI | ENE |
|-------|----|----------------------|------|----------|-----|--------|------|-----|
| | | CERTIFICAT | E O | F DEAT | н | | DEC | NO |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTME | ENT OF HEALTH AND | MENTA | L HYGIEN | E | | |
|------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------|------------------------------------|------------------------|---------------------|----------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | . 1 | | - | 2. DATE | OF DEATH | | EAR 3. TIM | E OF DEATH |
| | JOE | U. | | Dries | An | cust 2 | | | 510 H |
| 9 | 242-58-6650 | M 2 D F | 56 YRS. MONT | | 7 et | of BIRTH 1, Day, Year) 3 193 | | BIRTHPLACE Country) | (State or Foreign |
| DIRECTOR | 99. FACILITY NAME (If not institution, give stree PENINSULA REGIONAL RESIDENCE OF DECEMENT | | | SALISBURY | DEATH | | 9c. COUNTY WIC | OMICO | |
| JEC. | 10e. STATE 10b. COUNTY | | 10c. CITY, TOY | VN OR LOCATION | | | | 10d. IN | SIDE CITY |
| | MD Wice | SM:CO | SAI: | S Duly | | | 100 CIVITES | L | MITS? ES 2 NO |
| FUNERAL | 720 E. Church S | 上 | | 2180 | | | - 1 | U.S | , on this |
| BY FU | 11. MARITAL STATUS 1 Never Married | 2. WAS DECEDENT EVER IN U FORCES? 1 - YES IF YES, GIYE WAR OR DATE | 2 XNO | 13. WAS DECENDENT OF HISP If yes, specify Cuben, Mex 1 YES 2 TNO Spe | ican, Puerto F | I? (Specify Yee Rican, etc.) | or No — 14. | Black, White, | elack |
| TED | 15. DECEDENT'S EDUCAT (Specify only highest grade cor | mpleted) | 6a. DECEDENT'S USUA (Give kind of work de life. Do NOT use retin | one disting most of working | 16b. | KIND OF BUS | INESS/INDUS | TRY | |
| COMPLETED | 14 | College (1-4 or 5+) | , | DOIGR | | | sp | al | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) JONES TONES | 5 | | 18. MOTHER'S | TYUDE | 7 | Surnama) | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDR | RESS (Street and Number or Run | | | , State, Zip Co | 1 0 | |
| | DERHUDE LICIDS | | 720 E. | Chuich St. S | Alisbu | | | 301 | |
| | 1 M Buriel 2 Cremetion 3 Remova 4 Donation 6 Other (Specify) | trom State center | ACE AND DATE OF DIS bry, crematory or other plants | POSITION (Name of | 9/1/ | | cation — chy ISB4/4 | or Town, Stat | |
| | 21. SHINATURE OF PLACERAL SERVICE LICENTE | low | 7.8 | 22. NAME AND ADDRESS OF ANTHONY E. 30639 HAMA | WAID | tune | al Ha | we | 10 21852 |
| | 23. PART I. Enter the diseases for con shock, or heart failure. Lis | plicetions that caused to | he deeth. Do not er | nter the mode of dying, a | ich aa card | | ratory arrest | | pproximate sterval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | cer - live | er. | 12000 | | | neet and Dasth |
| | resulting in death) a | DUE TO (OR AS A C | ONSEQUENCE OF): | ABUSE. | | J | | | 6 mos |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A C | | H1345 8. | | | | | |
| FICA | CAUSE (Disease or Injury | DUE TO (OR AS A C | ONSEQUENCE OF: | | | | | | |
| E | thet initiated aventa resulting in death) LAST | | ondeduction of). | | | | | | |
| | PART II. Other algnificent conditions of | contributing to death but | not resulting in the | underfulne cause glump | n Part I | 24s. WAS AN | urnanav | | UTOPSY FINDINGS |
| DICAL | | | | | | PERFOR | MED? | AWAILAB | LE PRIOR TO |
| PHYSICIAN: MEDIC | | | | , | | | | | ES 2 NO |
| Ä | DID TOBACCO USE CONTRIB | | PLACE OF DEATH (Ch | | IN 🗆 | | | | |
| Sici | EXAMINER? | OSPITAL: | OTH | IER: | | | | | |
| H | 27. MANNER OF DEATH | 28e. DATE OF INJURY | 28b. TIME OF | Nursing Home 5 Residence 28c. INJURY AT | 7 | (Specify) CRIBE HOW th | JURY OCCUR | ED | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | WORK? 1 YES 2 NO | | | | | |
| - 10 | 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY — building, atc. (Specify) | At home, farm, street, | tectory, office | | ATION (Street e or Town, Stete) | nd Number or F | Rurel Route Nur | nber, |
| COMPLETED | | | | he time, data end place, end d ny opinion, death occured at ti | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c, LICENSE N | | and place, end | | | |
| TO BE | L flagmi | > Ms | / | D 23 | | | B - | 29-9 | 5 |
| - | Charles of Person who o | OMPLETED CAUSE OF BEAT | H (ITEM 27) (Type, Print) | | | | 10-1 | - | |
| | "AUGZ 9 1995 9 9 | SE REGISTRAR'S SIGNATI | URE | | | | | | |
| - 1 | | I | | | | | | | |

5. prince and a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec ALE THE RESIDENCE 2 , v v 1 was to the William American

at the same and apply the

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flor flored flored of may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

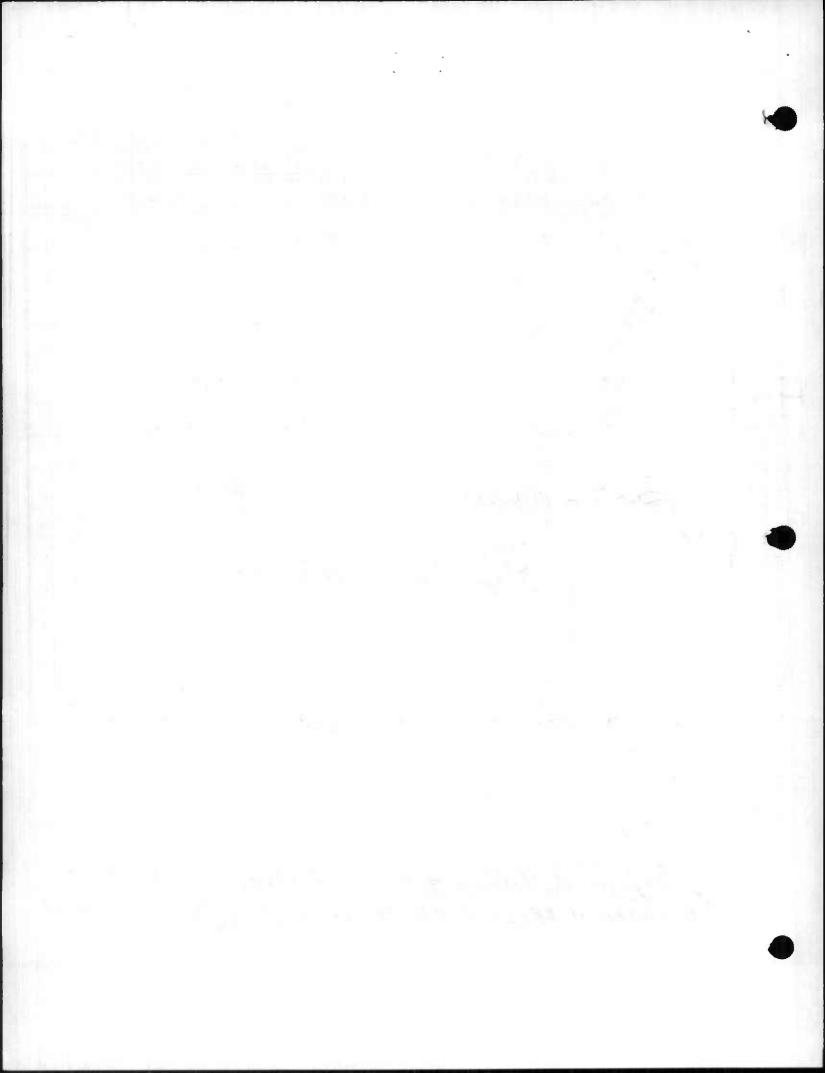
| | FOR 1 - STATE REGISTRAR | STATE OF MAI | RYLAND / DEPAR | TMENT OF H | | MENTAL | HYGIENE REG. NO. | | | |
|------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------|--------------------------|----------------|------------------------|--------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | | Y | 3. TI | ME OF DEATH |
| | JAMES | | | JACKSO | | AUG | UST 2 | 5, 1 | 995 | 11:23 P ^M |
| | 212-72-2277 | 5. SEX 6. | AGE (In yrs. lest birthday) 35 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF PEB. | Qay, Year) | 0 | Country | E (State or Foreign |
| er. | Se. FACILITY NAME (If not institution, give s | treet end number) | | 9b. CITY, TOWN (| OR LOCATION OF DE | | | 9c. COUNTY | OF DEATH | |
| OTO | PENTINSULA REGI | ONAL MED | ICAL CENT | ER SA | LISBURY | · | | WI | COMI | CO |
| DIRECTOR | MD 106. COUNT | Somerse | | TOWN OR LOCAT | | | | | | INSIDE CITY LIMITS? YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | Street | | 101 | ZIP CODE | 7 | | 10g. CITIZEN | OF WHAT | COUNTRY? |
| BY FUN | 1t. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR | YES 2 NO | If yes, sp | ENDENT OF HISPAI ecify Cuben, Mexica 2 XNO Specifi | in, Puerto Ric | | or No — 14. | RACE — A Black, Whi | mericen Indian, te, etc. Black |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | completed) | | USUAL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPATION CONTROL OCCUPAT | | | (IND OF BUSI | (ESTIMATE S | | |
| APLE | Elemantary/Secondery (0-12) | College (1-4 or 5+) | | DOPER | | ^ | LNAL | enac | F | |
| | 17. FATHER'S NAME (First, Middle, Last) | .1 | | | 16. MOTHER'S NA | - | - 1 | 4 | | |
| BE | 190, INFORMANT'S NAME (Type/Print) | NKS | 19b. MAILING | ADDRESS (Street of | MAR and Number or Rural | _ | acks | | de) | |
| ٩ | MARY JACKSO | ndh | 1445 | אך איני | | stield | | RULANI | | 1817 |
| | 20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | noval from State | 20b. PLACE AND DATE CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CO | ther place) | nme of | 9/3/9 | | WSON - City | | UD. |
| | 21. SIGNATURE OF AMERIAL SERVICE LI | CENSEE // | and o | 22. NAME A | ONY E | WAID | | crai t | 2181 | 7 |
| | 23. PART I limter the diseases of shock, or heart failure. | complications that co | eused the death. Do r | not aniar the mo | | h aa cardii | ac or reapile | atory arrest | , | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition reaulting in death) | Mult | iple anja | | | | | | | Onset and Death |
| z | | b | R AS A CONSEQUENCE O | r): | | | | | | |
| CERTIFICATION | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OF | R AS A CONSEQUENCE OF | F): | | | | | | |
| IFIC | CAUSE (Disesse or injury that initieted events | c. DUE TO (OI | R AS A CONSEQUENCE O | F): | | | | | | |
| ERIT | resulting in death) LAST | d | | | | | | | | |
| AL C | PART II. Other significant condition | ns contributing to de | eath but not resulting | In the underlyin | g ceuse given in | Part I. | 24a. WAS AN A PERFORA | | | E AUTOPSY FINDINGS |
| DIC | | | | | | | 1 XYES 2 | | COM | PLETION DF CAUSE DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONT | PIRLITE TO CALL | SE OF DEATH YE | S II NO I | UNCERTAI | NΠ | | | 1 (5) | YES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEA | | JONCERIA | | | | | |
| SIC | EXAMINER? 1 XYES 2 NO | 1 Inpetient 20 E | R/Outpatient 3 🗆 DOA | OTHER: 4 Nursing Hor | ne 5 🗆 Reeldence | 6 Other | (Specify) | | | |
| PH | 27. MANNER OF DEATH 1 Naturel 5 Pending | 28e. DATE OF IN. (Month, Day, | Year) IN. | IURY W | JURY AT ORK? | | RIBE HOW IN | | | |
| ВУ | 2 Accident Investigation | 8/25/ 280. PLACE OF II | 95 22. NJURY – At home, lerm, | | YES 2 X NO | 281 LOCA | TION (Street or | ad Alumbas os | Purel Pourte | Alumbar |
| TED | 3 Suicide 8 Could not be 4 Homicide determined | building, etc | ROAD W | | | City or | Town, State) , 413, U | PRINCES | SS ANNO | COUNTY MD |
| COMPLETED | onel T.F. | | knowledge, death occurr | | | e to the caus | e(s) end manr | ner se stated. | | menner es stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIE | ER . | | | 29c. LICENSE NU | MBER | | | | ith, Day, Year) |
| TO B | 30. NAME AND AGORESS OF PERSON W | HO COMPLETED CAUSE | OF DEATH (ITEM 27) (Type | , Print) | O.C.M | 1.E. | A | JGUST | 26, | 1995 |
| | DONALD GO CLEDI | GHT MD | | | | | | | | |
| | AUG2 9 1995 | i division to | SANTURE | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| ٠ | FOR STATE REGISTRA |
|---|--------------------------|
| | 1. DECEDENT'S |
| | Montr |
| | 4. SOCIAL SECU |
| | 218-3 |
| | 9a. FACILITY NA |
| | Peninsu |
| 1 | RESIDENCE |
| ı | 10a. STATE |

| STATE OF MARYLAND / DEP | ARTMENT OF | HEALTH AN | D MENTAL | HYGIENE |
|-------------------------|------------|-----------|----------|---------|
| CERT | FICATE O | F DEATH | | REG NO |

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO | | |
|------------------|--------------------------------------------------------------------|-----------------------------------------|---------------------------|-------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Montrue Skeet | ter Jones | 3 | | | THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE S | | AR O O O N |
| | 4. SOCIAL SECURITY NUMBER | | E (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 95 8:00 A M BIRTHPLACE (State or Foreign |
| | 218-30-2156 | 1 🗆 M 2 💢 F | 87 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | Country) |
| | Se. FACILITY NAME (If not institution, give a | street and number) | - 1000 | Oh CITY TOWN | OR LOCATION OF D | 04-21-19 | | rginia |
| Œ | | | | | | EATH | 9c. COUNTY | |
| 0 | Peninsula Regiona | I Medical C | enter | Salisbu | ıry | | Wicom | nico_ |
| E C | 10a. STATE 10b. COUNT | Υ | 10c CIT | Y, TOWN OR LOCAL | TION | | | 404 1110105 0171 |
| E | Virginia Accom | ack | | | | | | 10d. INSIDE CITY X LIMITS? 1 YES 2 NO |
| | 10s. STREET AND NUMBER | ack | | reenback | | | | |
| ₹ | | | | 10 | f. ZIP CODE | | | OF WHAT COUNTRY? |
| FUNERAL DIRECTOR | Church Street | | | | 23356 | | US | SA |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 2 YE | R IN U.S. ARMED | 13. WAS DEC | ENDENT OF HISPAI | NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.) | or No- 14. | RACE — American Indian, Black, White, etc. |
| ВУ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR | | | 2 NO Specif | | | Specify: |
| | 3 Historica 4 Divorces | | | | | | | White |
| 8 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S | USUAL OCCUPATION | ON of working | 16b. KIND OF BU | SINESS/INDUST | RY |
| Ш | Elementary@econdary (0-12) | College (1-4 or 5+) | | work done during mo se retired.) | | | | |
| P P | | | Hous | e wife | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | |
| BE C | William Skeeter | | | | Josep | hine Risle | ev. | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING | ADDRESS (Street a | and Number or Rural | Route Number, City or Tow | n. Stata. Zin Cod | fel |
| 임 | Virginia Lee Mari | ner | 200 S | and Cast | le Rd. | Fruitland | Md | 21826 |
| | | | Ob. PLACE AND DATE | | | DATE 20c. LO | | |
| | 20a METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Rem | oval from State | emptery prementary or o | Denoise Cit | Comoto | ry8/22Gree | cation - day | or lown, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | | TION TEAM | KIIII CIC | y cenete | 170/24GIE | HDackv | ille, va. |
| : | | 2 A | | Melso | nd Address of FA | il Home | | |
| | Scott S. | Melso | | | | comoke Cit | v. Md. | 21851 |
| | 23. PART I. Enter the diseases, or o | complications that caus | ed the deeth. Dp i | | | | | |
| | shock, or heart fellure. | List Dnly one cause on | each line. | | | | | Interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | 50 | 3434 | | | | | Onset and Death |
| - 1 | resulting in death) | · Jej | A CONSEQUENCE O | _ | | | | 1 day |
| 1 | | Oue to law a | A CONSEQUENCE O | P): | 0-0- | ^ | 4 | 0/ |
| CERTIFICATION | Sequentielly list conditions, | · Cley | recc | eer 1 | DOC. | meum | onia | 1 day |
| Ē | if any, leading to immediate cause. Enter UNDERLYING | DUE TOPOR AS | A CONSEQUENCE O | F): | U | | | |
| 3 | CAUSE (Disease or injury | c | | | | | | |
| E | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE O | P): | | | | |
| EB | Tooling in death) Exo | d | | | | | | |
| | PART ii. Other algnificent condition | a contributing to death | but not resulting | In the underlyin | a cause alven in | Part I. 24s, WAS AN | ALITTORNA | |
| EDICAL | | | | | | PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | Caronary De | otic Hea | y suse | are c | C/7/ | 1 YES 2 | 50 NO | OF DEATH? |
| ž | Ceronary we | kery se | sease. | perso. | alex | | | 1 TYES 2 NO |
| ä | Diverticulit | is C Color | i Resel | ten: Cs | Costom | y | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26. Pt | ACE OF OEATN (Ch | ck only one) | | |
| SS | 1 TES 2 NO | HOSPITAL: 1 ☐ Inpetient 2 X ER/O | utpatient 3 DOA | OTHER: | e 5 □ Rasidence | 6 Other (Specify) | | |
| Ŧ | 27. MANNER OF DEATH | 28a. DATE OF INJUR | Y 28b. TIM | E OF 28c, INJ | URY AT | 28d. DESCRIBE NOW I | NJURY OCCURE | D |
| | 1 Natural 5 Pending | (Month, Day, Year |) INJ | | PRK? | | | |
| BY | 2 Accident Investigation 3 Suicide & Could get be | 28a. PLACE OF INJUI | RY — Al home, farm, | | | DOLLOCATION (Co | | |
| | 4 Homicide 6 Could not be | building, etc. (S | pecify) | attent, factory, other | | 281. LOCATION (Street in City or Town, State) | ing Number or H | urai rioute Number, |
| COMPLETED | 29a, CERTIFIER | | | | | | | |
| 린 | (Check only 1 K CERTIFYING PNYSI | CIAN: To the best of my kno | | | | | | |
| ō | one) 2 MEDICAL EXAMINE | R: On the basis of examinat | ion and/or investigation | n, in my opinion, d | eath occured at the | lime, data and place, an | d due to the cer | use(a) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 | | | 29c. LICENSE NUM | ABER | 29d, DATE SIG | ENED (Month, Day, Year) |
| BE | Elegario Tr | 15ella- | ship | | | | | 19-95 |
| 2 | 30. NAME AND ADDRESS OF PERSON WN | O COMPLETED CAUSE OF I | DEATH (ITEM 27) (Type | Print) | 1 -13 | | 0 - | 1-1-15 |
| | | | | | Echna | ONEL OF | PIOENEI | 04001010 |
| 6 | 31. DATE FILED (Month, Day, Year) | 12 DEMOTION OF | MATURE . | TAI BE | CCHWO! | Upra, CK | ISTICU | PMP 21817 |
| 1 | ALIC O 4 100 | JE. REMISTHAN'S SIC | SHATURE | | | | | |



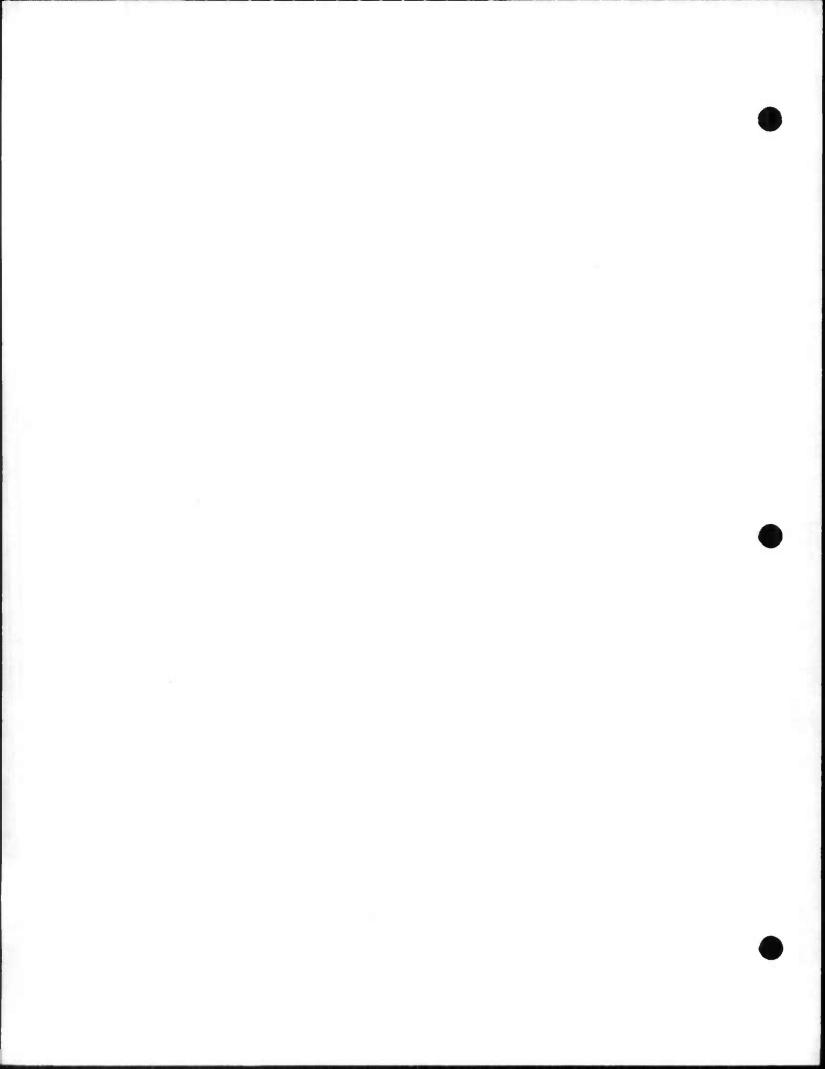
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| | 1. DECEDENT'S NAME (First, | | | | | | | | | | OF DEATH | | | 3. TIME OF DEATH |
| | Mary | Judy | | | | | | | | Aua | | 1995 | YEAR | 7:30PM |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER | DAYS | IF UNDER 24 | HRS. | 7. DATE | OF BIRTH | | B. BIRTHP Country) | LACE (State or Fore |
| | 214-42-0265 | | 1 M 2 X F | 59 | YRS. | MONTHS | DAYS | HOUNS | MIN. | Ap | ri1 21 | 193 | | MD |
| l ~ | 9a. FACILITY NAME (If not ins | stitution, give sti | reet and number) | | | 9b. CITY | , TOWN O | R LOCATION | OF DE | ATN | | 9c. COUN | NTY OF DE | |
| Ē | 6F Ft Cumber | | omes | | | Cum | ber1 | .and | | | | A110 | egany | 7 |
| DIRECTOR | 10a. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN C | OR LOCAT | ION | | | | | | 10d. INSIDE CITY |
| ä | MD | $All\epsilon$ | egany | | Cı | mber | cland | 3 | | | | | Ι, | LIMITS? |
| A | 10e. STREET AND NUMBER | | | | | | | ZIP CODE | | | | 10g. CITI | | IAT COUNTRY? |
| FUNERAL | 6F Fort Cu | mberla | and Homes | 5 | | | | 21502 | | | | US | A | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 1 | Manadada | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. | | t3. | WAS DECI | ENDENT OF selfy Cuban, | NISPANI | C ORIGIN | 7 (Specify Yes | or No- | 14. RACE - | - American Indian, White, etc. |
| B | 3 ▼ Widowed 4 Divor | | IF YES, GIVE W | | X | | 1 TYES | | Specify: | | mean, etc.) | - 1 | Specify: | |
| | 15, DECE | EDENT'S EDUC | ATION | 160 | DECEDENT'S | IISUAL O | CCUPATIO | iN. | | 105 | KIND OF BUS | CINEGO (INIO | I IOTOV | white |
| ETE | | highest grade o | | | (Give kind of a life. Do NOT us | work done | | | | 100. | KIND OF BUS | SINE 35/IND | USTHY | |
| PL | 12 | 12) | Conege (I-4 or 5 4 | | Homem | akor | | | | | O T | Tam a | | |
| COMPLETED | 17. FATHER'S NAME (First, Mic | ddle, Last) | | | TICALICALITY. | ance I | | 18. MOTNE | R'S NAN | AE (First, A | Own F Aiddle, Maiden | | | |
| BE C | Hubert H | <i>lershb</i> | erger | | | | | Aı | rett | a Mo | Kenzi | 9 | | |
| TO B | 19a. INFORMANT'S NAME (7) | rpe/Print) | | | 19b. MAILING | ADDRESS | S (Street ar | | _ | | oer, City or Towi | - | Code) | |
| F | Jansen Jud | У | | | 478 Be | eall | Stre | eet Ro | cad; | Fro | stbur | a. M | 21! | 532 |
| | 20a METHOD OF DISPOSITION 1 ABurial 2 Cremation | ON n 3 🗆 Ramo | wel from State | 20b. PLAC | EANDDATE | OF DISPOS | ITION /Nar | me of | | DATE | 7 | CATION — | | |
| | 4 Donation 5 Other (| | | Hil | lcrest | | | | | 08/ | 30 Cu | mber. | land, | MD |
| | 21. SIGNATURE OF FUNERAL | . SERVICE LICE | ENSEE | // | | | | D ADDRESS | | | L Home | | | |
| | yanes | 1 K | Jeans | SUL | 1) | | | rland | | | 21502 | | | |
| | 23. PART I. Enter the dis | seeses, or co | omplications the | t caused the | deeth. Do r | not enter | the mod | de of dying | , such | as card | lac or reapi | ratory arm | est, | Approximate |
| | IMMEDIATE CAUSE (Fina | | , | oc on caon n | 110. | | | | | | | | | Interval Bety |
| | | | | | | | | | | | | | | Onset and D |
| | disease or condition resulting in death) | + . | . Chroni | c Obstr | ructiv | e Pu | 1mon | ary d | lise | | | | | Onset and D |
| | | + . | | C Obsti | | | 1mon | ary d | lise | | | | | |
| NO | resulting in death) Sequentially list condition | ona, ob. | DUE TO | (OR AS A CONS | SEQUENCE OF | F): | 1mon | ary d | lise | | | | | Onset and D |
| ATION | resulting in death) Sequentially list condition if any, leading to immed | ona, | DUE TO | | SEQUENCE OF | F): | 1mon | ary d | lise | | | | | Onset and D |
| FICATION | Sequentially list condition if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or injure) | ona, flate NG | DUE TO | (OR AS A CONS | EQUENCE OF | F): F): | 1mon | ary d | lise | | | | | Onset and D |
| RTIFICATION | resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN | ona, flate NG ry | DUE TO | (OR AS A CONS | EQUENCE OF | F): F): | 1mon | ary d | lise | | | | | Onset and D |
| CERTIFICATION | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST | ona, diate NG ry | DUE TO | (OR AS A CONS | SEQUENCE OF | F): F): F): | | | | ase | | | | Onset and D |
| O | Sequentially list condition if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events | ona, diate NG ry | DUE TO | (OR AS A CONS | SEQUENCE OF | F): F): F): | | | | ase | 24a, WAS AN PERFOR | | A | Onset and D Uk vrs |
| DICAL C | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST | ona, diate NG ry | DUE TO | (OR AS A CONS | SEQUENCE OF | F): F): F): | | | | ase | | | C | Onset and D Uk yrs |
| MEDICAL C | resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurn that initiated events resulting in death) LAST | ons, dilate NG c. d. d. d. d. d. d. d. d. d. d. d. d. d. | DUE TO DUE TO DUE TO contributing to | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not | EQUENCE OF | F): F): In the un | iderlying | ceuse giv | ren in P | ase | PERFOR | | C | Onset and D Uk yrs |
| MEDICAL C | resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST PART II. Other algnificant | ona, diate short conditions | DUE TO DUE TO DUE TO contributing to | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not | EQUENCE OF | F): F): In the un | nderlying | | ren in P | ase | PERFOR | | C | UK YES |
| MEDICAL C | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurt that initiated events resulting in death) LAST PART II. Other algnificant DID TOBACCO US | one, filate NG c. d. d. d. d. d. d. d. d. d. d. d. d. d. | DUE TO DUE TO DUE TO CONTributing to HOSPITAL: | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not USE OF DE | EQUENCE OF DEAT | F): In the un OTHER | NO Donly one) | Ceuse giv | ren in P | ase | PERFOR | | C | UK YES |
| MEDICAL C | resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injurt that initiated events resulting in death) LAST PART II. Other algnificant | one, filate NG c. d. d. d. d. d. d. d. d. d. d. d. d. d. | DUE TO DUE TO Contributing to | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not USE OF DE 26. PL | EQUENCE OF TEATH YEACE OF DEAT | F): F): Th (Check of Other 4 Num | NO Donly one) | UNCEI | RTAIN | ase | PERFOR | MED? | 1 | UK YES |
| MEDICAL C | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurn that initiated events resulting in death) LAST PART II. Other algnifican DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? YES 2 NO 27. MANNER OF DEATH Netural 5 P | ons, flate NG ry d. d. d. d. d. d. d. d. d. d. d. d. d. | DUE TO DUE TO DUE TO COntributing to CIBUTE TO CA | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not USE OF DE 28. PL ER/Outpatient INJURY | EQUENCE OF DEAT | F): In the un OTHER | NO Only one) | UNCEI | RTAIN | ase | PERFOR | MED? | 1 | UK YES |
| BY PHYSICIAN: MEDICAL C | PART II. Other algnifican DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? YES 2 NO 27. MANNER OF DEATH Netural 5 PA | one, filate NG ny d. d. d. d. d. d. d. d. d. d. d. d. d. | DUE TO DUE TO DUE TO B CONTributing to BUSPITAL: Impetient 2 28e. DATE OF (Month, Dec.) | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not USE OF DE 28. PL ER/Outpatient INJURY INJURY FINJURY — At I | EQUENCE OF DEAT 1 DOA 1 NJ | F): F): OTHER 4 Nun E OF URY | NO Only one) 3: sing Nome 28c. INJU | UNCEI | RTAIN | ase | PERFOR | NJURY OCC | 1 TURED | Onset and D UK Yrs VERE AUTOPSY FINDS MARILABLE PRIOR TO DOMPLETION OF CAU F DEATH? YES 2 NO |
| ED BY PHYSICIAN: MEDICAL C | PART II. Other algnifican DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? YES 2 NO 27. MANNER OF DEATH Netural 5 PA Accident 3 Suicide 8 C | ons, flate NG ry d. d. d. d. d. d. d. d. d. d. d. d. d. | DUE TO DUE TO DUE TO B CONTributing to BUSPITAL: Impetient 2 28e. DATE OF (Month, Dec.) | (OR AS A CONS (OR AS A CONS (OR AS A CONS deeth but not USE OF DE 28. PL ER/Outpatient INJURY sy, Year) | EQUENCE OF DEAT 1 DOA 1 NJ | F): F): OTHER 4 Nun E OF URY | NO Only one) 3: sing Nome 28c. INJU | UNCEI | RTAIN | 28d. LOCA | PERFOR | NJURY OCC | 1 TURED | Onset and D UK Yrs VERE AUTOPSY FINDS MARILABLE PRIOR TO DOMPLETION OF CAU F DEATH? YES 2 NO |
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YES 2 NO |

124 w 3rd st Cumb MD 21502

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ul Snow M.D. Month, Day (Nav) AUG 2 8 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the busined by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fied within 72 hours after death with the State Dept. of Health and Mental Hygher prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Inlury, or other traumatte event, the medical examiner must be medical at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO | | | |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------|-------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| | MATILDA | EMMA | | KEN | TON | AUG. 21 | 1995 | | |
| | 4. SOCIAL SECURITY NUMBER | | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | 9:40 P M | |
| | 219-01-9430 | 1 M 2 N F | | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) DEC. 27, | Cour | HPLACE (State or Foreign try) | |
| | | | 9 4×RS. | | | | 1900 MARYLAND | | |
| 1 | 9a. FACILITY NAME (If not institution, give | | | 9b. CITY, TOWN C | OR LOCATION OF D | EATH | 9c. COUNTY OF | DEATH | |
| 18 | WESLEYAN HEALTH | CARE CENTER | | DENTON | | | CAROLI | NE. | |
| 15 | RESIDENCE OF DECEDENT | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | | 10c. CIT | Y, TOWN OR LOCAT | TION | | | 10d, INSIDE CITY | |
| <u>_</u> | MARYLAND CAR | OLINE | FEI | DERALSBU | RG | LIMITS? | | | |
| 7 | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | |
| E | 4472 FEDERALSBUR | G HIGHWAY | | | 21632 | | 11 | SA | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEOENT EVE | D IN II C ADMED | 142 480 050 | | HC ORIGIN? (Specify Yes | | | |
| 三 | 1 Never Married 2 Married | FORCES? 1 Y | ES 2 XNO | If yes, sp | ecify Cuban, Maxica | n, Puerlo Ricen, etc.) | Black | E — American Indian, ck, White, atc. | |
| B≺ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OF | R DATES | t 🗌 YES | 2 NO Specif | y: | Spe | WHITE | |
| ED | 15. DECEDENT'S EDU | ICATION | 14. 0000000000 | | | | | WILLE | |
| 1 2 | (Specify only highest grade | | (Give kind of v | VOIAL OCCUPATION WORK done during mo | on st of working | 16b. KIND OF BU | SINESS/INDUSTRY | | |
| ا تا ا | Elementary/Secondary (0-12) | College (1-4 or 5+) | ilfe. Do NOT us | | | | | | |
| ₹ . | | | HOME | EMAKER | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surname) | | | | | | | | |
| ш | HERMAN LUBBA EMMA KRUEGER | | | | | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | |
| 유 | WANDA Y. NORTH 4472 FEDERALSBURG HIGHWAY, FEDERALSBU | | | | | | | RG.MD 21632 | |
| | 29s. METNOD OF DISPOSITION 20b BLACE AND DATE OF DISPOSITION Allowed 20c. I DATE 20c. LOCATION CO. T. T. C. C. C. C. C. C. C. C. C. C. C. C. C. | | | | | | | | |
| | 1A Burlet 2 Cremation 3 Ramoval from State Company of other (Specify) 4 Donation 5 Other (Specify) A 25 HURLOCK, MARYLAND | | | | | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LA | | DMILL WASI | I INGION (| JEMETEKI | 0/23 NOK | LUCK, MA | KILAND | |
| | THE STATE OF STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE | 74 | 1// | ZELLI | ER FUNER | AL HOME, P | . O. BOX | 207. | |
| | 12 Mureral | Hele | Rec | 106 1 | MAIN STR | EET. EAST | NEW MARK | ET, MD 21631 | |
| 0 | 23. PART J. Entar the diseasea, or | complications that cau | sed the deeth. Do r | of enter the mo | de of dving suc | h as cardiac or read | erton erret | Approximate | |
| | snock, or heart failure. | List only one cause or | each line. | | | aa carata or resp. | atory arrest, | Interval Between | |
| | IMMEDIATE CAUSE (Final disease or condition | 11. | + FI | | | | | Onset and Death | |
| | resulting in death) | 8. Trans | 1 all | we | | | | | |
| | Sequentially list conditions. In Sequentially list conditions. | | | | | | | | |
| Z | Sequentially list conditions, | h tu | ware | Vilyaco | erdial. | Infare | lin | Vegas | |
| CERTIFICATION | If any, leading to immediate | | | | | | | | |
| 2 | cause, Enter UNDERLYING CAUSE (Disease or Injury | e He | pertino | u | | | | 1 care | |
| 트 | thet initiated eventa | DUE TO (OR A | II & CONSEQUENCE OF | Pic. | | | | | |
| E | resulting In death) LAST | | | | | | | | |
| | PART II O. 1 | NA | | | | | | | |
| EDICAL | PART ii. Other algnificent condition | as contributing to death | h but not reaulting | in the underlying | g ceuse given in | Part I. 24s. WAS AN PERFOR | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| 8 | GERD | | | | | 1 YES 2 | | COMPLETION OF CAUSE OF DEATH? | |
| | | | | | | | | | |
| Σ | | | | | | | | 1 YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | Γ | | | ADE OF CENTURE | | | | |
| 亘 | EXAMINER? | HOSPITAL: | -11 | OTHER: | ACE OF OEATN (Ch | eck only one) | | | |
| 5 | 1 VES 2 NO | 1 Inpetient 2 ER/O | | 4 Nursing Hom | | 6 Other (Specify) | | | |
| 1 . | 27. MANNER OF DEATH | 28a. DATE OF INJUR (Month, Day, Yea | | | URY AT | 28d. OEŞCRIBE NOW I | NJURY OCCUREO | | |
| PHYSICIAN: | . Name = | | | | rES 2 NO | | | | |
| | t Natural 5 Pending Investigation | | | | | 28L LOCATION /Street | and Number or Rural | | |
| B≺ | 2 Accident Investigation 3 Suicide 8 Could not be | 28s. PLACE OF INJU | JRY — At home, ferm, s | street, lactory, office | | | | Houte Number, | |
| B≺ | 2 Accident Investigation | 28a. PLACE OF INJU building, etc. (S | JRY — At home, lerm, a pecify) | street, lactory, office | | City or Town, State) | | Houte Number, | |
| B≺ | 2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined | building, etc. (S | ipecify) | | | City or Town, State) | | Ploute Number, | |
| B≺ | 2 Accident 3 Sulcide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNYS | iCIAN: To the best of my kn | owledge, death occum | ed at the time, date | and place, and due | City or Town, State) to the cause(a) and mei | nner se stated. | | |
| B≺ | 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNYS | BICIAN: To the best of my kn | owledge, death occum | ed at the time, date | and place, and due | City or Town, State) to the cause(a) and mei | nner se stated. | | |
| COMPLETED BY | 2 Accident 3 Sulcide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNYS | BICIAN: To the best of my kn | owledge, death occum | ed at the time, date | and place, and due | City or Town, State) to the cause(a) and mei time, data and place, an | nner se stated. | | |
| BE COMPLETED BY | 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNYS | BICIAN: To the best of my kn | owledge, death occum | ed at the time, date | and place, and due | City or Town, State) to the cause(a) and mei time, data and place, an | nner se stated. | (a) and manner as stated. D (Month, Day, Year) | |
| COMPLETED BY | 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNVS 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE BS CERTIFIE 30. NAME AND ADDRESS OF PERSON WITH | ician: To the best of my kn ER: On the best of examina | owledge, death occurrention end/or investigation | od at the time, date in, in my opinion, d Print) | and place, and due eath occured at the 29c. LICENSE NUI | City or Town, State) to the cause(a) and mei time, data and place, an | oner se stated, and due to the cause | (a) and manner as stated. D (Month, Day, Year) | |
| BE COMPLETED BY | 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNYS 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE US CERTIFIE | ician: To the best of my kn ER: On the best of examina | owledge, death occurrention end/or investigation | od at the time, date in, in my opinion, d Print) | and place, and due eath occured at the 29c. LICENSE NUI | City or Town, State) to the cause(a) and mei time, data and place, an | oner se stated, and due to the cause | (a) and manner as stated. D (Month, Day, Year) | |
| BE COMPLETED BY | 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER t CERTIFYING PNVS 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE BS CERTIFIE 30. NAME AND ADDRESS OF PERSON WITH | BICIAN: To the best of my kn ER: On the best of examina TO COMPLETED CAUSE OF V, MD P.O. | pecify) rowledge, death occurrention end/or investigation DEATN (ITEM 27) (Type, BOX 122 G | od at the time, date in, in my opinion, d Print) | and place, and due eath occured at the 29c. LICENSE NUI | city or Town, State) to the cause(a) and mer time, data and place, an | oner se stated, and due to the cause | (a) and manner as stated. D (Month, Day, Year) | |

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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within four ster death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | REGISTRAR | | CER | RIFIC | ATE C | OF DEATH | REG. NO. | | | | |
|-----------------------------------------------------------|----------|-------------------------------------------------------------------------------------|-----------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------|-------------------------------------------------|---------------------------------------|--------------------------------------------------|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) Lucinda | f. Kreiling | | | | | 2. DATE OF DEATH | of DEATH 3. TIME OF DEATH 9:35 P.M. M | | | |
| | | 4. SOCIAL SECURITY NUMBER | | E (In yrs. lest bir | rtholay) IF | UNDER 1 YEA | AR IF UNDER 24 HRS. | 7 DATE OF BIRTH | 0.6 | HRTHPLACE (State or Foreign | | |
| | | 218-16-3496 | 1 🗆 M 2 💢 F | 80 | YRS. MO | NTHS DAY | 'S HOURS MIN. | Nov. 14,19 | 14 19 | laryland | | |
| | NG. | sa. FACILITY NAME (If not institution, give s Frostburg Vi. | otreet and number) Llage Nursin | ng Home | 96 | Frost | on LOCATION OF DI | EATH | 9c. COUNTY | of DEATH egany | | |
| | 5 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| | DIRECTOR | Maryland 10b. COUNT Maryland Al. | legany | 1 | ioc. city, to | ostbu | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| | FUNERAL | 100. STREET AND NUMBER 11 W. Main | St. | | 101, ZIP CODE 21532 | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| | 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YE | IN U.S. ARME! | D | 13. WAS | DECENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No — 14, 1 | RACE — American Indian, | | |
| | BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YE | | If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 (NO Specify: Black, White, etc. Specify: White | | | | | | | |
| | ETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DECER | DENT'S USL | JAL OCCUP | ATION | 16b. KIND OF BUS | INESS/INDUST | RY | | |
| | PLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do | ive kind of work done during most of working Do NOT use retired.) Own Home | | | | | | | |
| 99 | COMPL | 17, FATHER'S NAME (First, Middle, Last) | | | | | T as asserting the | | | | | |
| od at or | BE CC | Harry R. Tayl | or | | 18. MOTHER'S NAME (First, Middle, Melden Surname) Elizabeth Jenkins | | | | | | | |
| notifie | 5 | John A. Kreiling | | 196. M | 3146 | DAESS (Stre Warri | or Drive, | Route Number, City or Town Cresaptown | n, Store, Zip Cod | 21502 | | |
| or removal. medical examiner must be notified at once. | | 20a, METHOD OF DISPOSITION 1 | | Ob. PLACE AND | | | (Name of Park | 8/23 Fr | cation - city | or Town, Stata | | |
| aminer | | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | | | cium 57 Fro | | | | |
| oval. | | Alknot | Asis | | | 1 | | | | Md. 21532 | | |
| | | 23. PART 1. Enter the diseasea, or shock, or heart failure. IMMEDIATE CAUSE (Finel | List only one ceuse on | sed the deeth seech line. | . Do not | enter the | | | ratory arrest, | Approximate Interval Between Onset and Death | | |
| event, the | | disesse or condition resulting in desth) | Congress | NC SIA CONSEQUE | TR | MI | Mark | lure du | | 6 yrs | | |
| - e | NO | Sequentially list conditions, | Lett. 6 | lenger | icul | m | Diasta | lic Sy | Hung | han Cours | | |
| prior to | CATION | If any, leading to immediate cause. Enter UNDERLYING | OUE TO (OR AS | S A CONSEQUE | NCE OF): | | | / | 0 | | | |
| Hygiene prior to buria or other traumatic | CERTIFIC | CAUSE (Disease or Injury thet initiated events resulting in death) LAST | DUE TO (OR AS | S A CONSEDUE | INCE OF): | | | | | | | |
| Mental jury, o | | | d | | | | | | | | | |
| any injury, | EDICAL | PART II. Other algorificant condition | ns contributing to deeth | 6 | // | 1// | 1 1000 | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| rs am | ŏ | Church | - Coura | TiVE | 1 | KM | | 1 TYES 2 | NO | OF DEATH? | | |
| shows ar | M | DID TOBACCO DISE C | ONTRIBUTE TO | CALLEE | 25 | EATLI | VEC CO NO | * | - 1 | 1 - YES 2 17 NO | | |
| Z3 S | AN | 25. WAS CASE REFERRED TO MEDICAL | ONTRIBUTE TO | CAUSE | OF DI | | | M | | | | |
| State Dept. | SICI | EXAMINER? | HOSPITAL: | | - 0 | THER: | B. PLACE OF DEATH (Ch | | | | | |
| 6 § | HYS | 27. MANNER OF DEATH | 1 Inpetient 2 ER/O | - | 8b. TIME OF | | Home 5 Residence | 8 Other (Specify) 28d, DESCRIBE HOW II | HIRV OCCURE | 0 | | |
| death with | BY PI | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year | | INJURY | | WORK? | 200. DESCRIBE HOW II | NONT OCCORE | | | |
| 28 I | TED | 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJU building, atc. (S | RY — At home, pecify) | , farm, stree | ol, factory, o | office | 28f. LOCATION (Street a City or Town, State) | nd Number or R | ural Route Number, | | |
| ltem Item | LE I | 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the bast of my kn | owledge, death | occurred at | t the time. | data and place, and due | to the cause(a) and men | ner as stated | | | |
| ANT: # | COMPL | one) 2 MEDICAL EXAMINI | R: On the beats of examine | | | | | | | use(a) and menner as stated. | | |
| be filed within 72 h | BE | THE BIGHATURE AND TITLE OF CENTIFIE | un & | / m | ,0 | | 29c LICENSE NUI | 1951 | 29d. DATE BIG | ED (Month, Day, Year) | | |
| = ۵ | ٩ | 30. HAME AND ADMINESS OF PERSON AN | 1.0 | | | | 7 | | 1 | | | |
| | | Chang Oh. | M.D. 48 T | arn Te | rrace | e Fr | ostburg. N | d. 21532 | | | | |
| | | AUG 2 2 1995 | 12. REGISTRAM'S SI | n-Randall | 4 | | | | | | | |

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3. TIME OF DEATH

REG. NO.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| (68760 |
|----------|
| BOX |
| P.0 |
| RECORDS, |
| OF VITAL |
| DIVISION |

2. DATE OF DEATN August 16,1995 MONA KATHLEEN KAVANAUGH 1:40 P.M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Mar. 23, 1917 DAYS 78 214-05-5532 1 M 2 X F West Virginia permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR IONS MANOR NURSING HOME CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY **CUMBERLAND** YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 217 SARATOGA STREET 21502 U.S.A. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cuben, Maxicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 YES 2 NO Specify: Specify: WHITE ВУ 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig 10 Elementary/Secondary (0-12) College (1-4 or 5 +) HOMEMAKER 12 HOME detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Sumemi ROSS CHARLES COLGROVE RHODA BELL CUNNINGHAM 8 to BE notified 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 page 5 s PATRICK T. KAVANAUGH 406 PULASKI ST.-CUMBERLAND, MD 21502 90 20e. METNOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION — City or Town, State must t DATE funeral director, 4 Donation 5 Other (Specify) CEM CUMBERLAND, MD PFTFR PAIII event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, MONAL ion, or removal. 202 GREENE ST., CUMBERLAND, MD 21502 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between 6 IMMEDIATE CAUSE (Finel Onset and Death cremation, disease or condition resulting in death) completely ar Cenoma DUE TO (OR AS A CONSEQUENCE OF): prior to burial, traumatic pue CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING attending physician 8 death certificate CAUSE (Disesse or injury other Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the 24s. WAS AN AUTOPSY PERFORMED? the MEDICAL WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO requires that shows any COMPLETION OF CAUSE 1 TYES 2 X NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: AW 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) State 1 Hem HOSPITAL: OTHER:
4 A Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 X NO OR ATTENDING PHYSICIAN: 1 Inpatient 2 ER/Outpatient 3 DOA the 27. MANNER OF DEATN 28s, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED marked, With this 1 X Natural 1 YES 2 NO BY death 2 Accident DIRECTOR: After 28 Is n 28e. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 3 Sulcide 26t. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be after 4 Homicide hours Hem 29a. CERTIFIER
(Chack nnlv 1 K) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end plecs, and due to the cause(s) and menner as stated. TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If IN 2 MEDICAL EXAMINER: On the 29b. SIGNATURE AND TITLE OF CERTIFIER MO7473 29d. DATE SIGNED (Month, Day, Year) BE 9 9 30. NAME AND ADDRESS OF PROSON WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WAYNE C. SPIGGLE, M.D.-BMG 912 SETON DR., cumberland,MD 21502

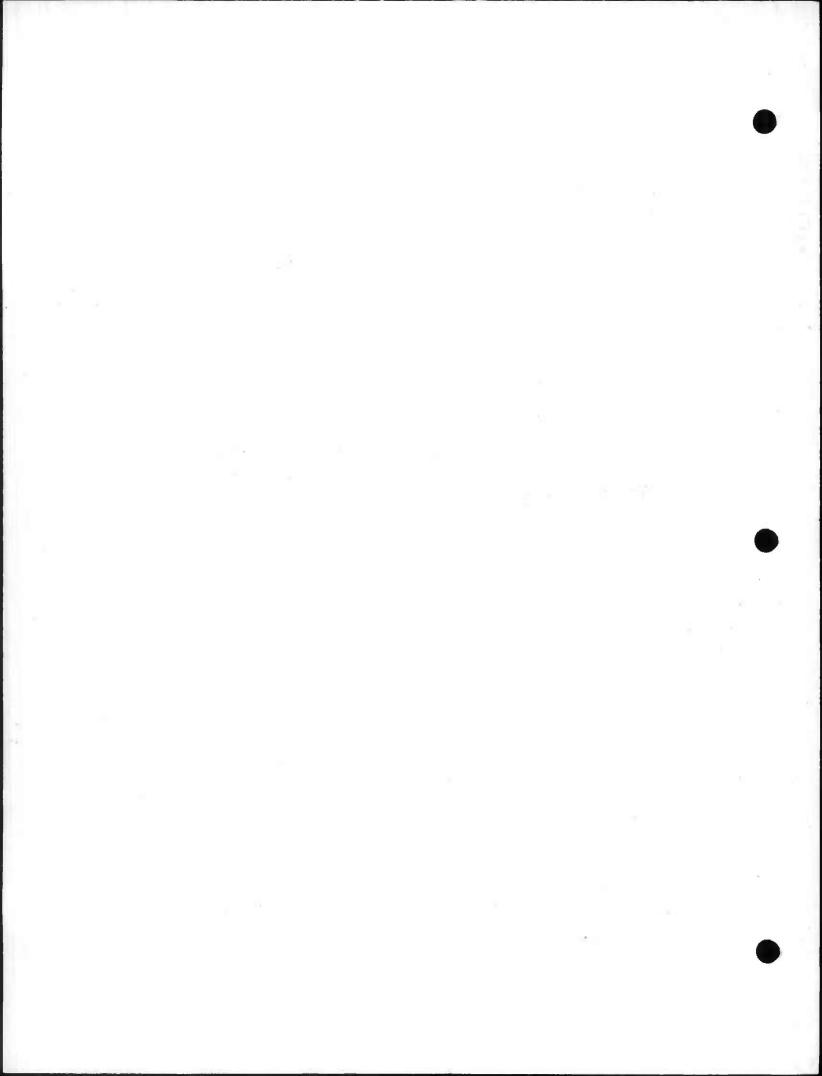
32. REGISTHAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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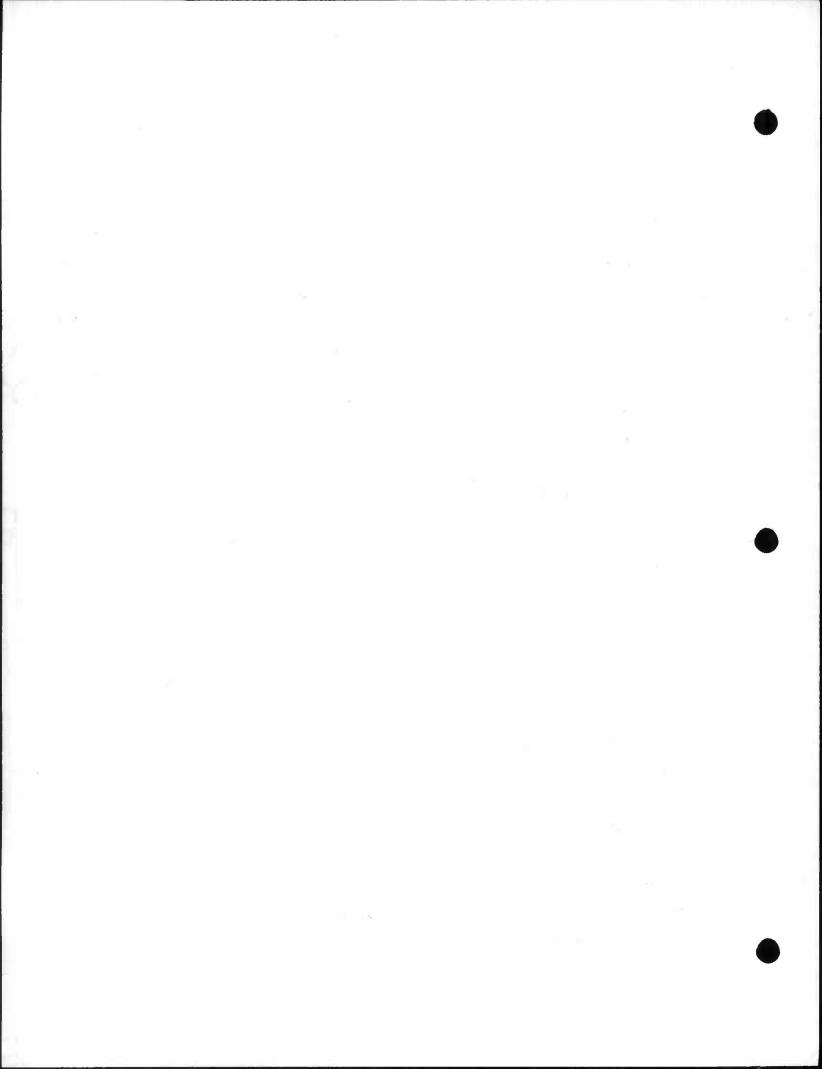


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thous after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------|--------------------------------------|-----------------------------------------|-------------|------------|--------------|------------|-----------------------------------------------|------------|---------------|-------------------------------------------|
| | WILLIAM | HENRY | KEM | IP | | | | | | AUGUST | AY 1 | 995 | 4:45 p ^M |
| | 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 6. AGE (In yrs. les | st birthday) | IF UNDE | | | R 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTI | IPLACE (State or Foreign |
| | 217-10-108 | | 1 M 2 🗆 F | 80 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) MAY 25 10 | 115 | Count | MARYI.AND |
| | 9a. FACILITY NAME (If not in | | | | | | | | ON OF DE | | | UNTY OF D | |
| E | SACRED HEART HOSPITAL CUMBERLAND ALLEGANY | | | | | | | NY | | | | | |
| | RESIDENCE OF DEC | 10b. COUNTY | , | | 10c. CIT | Y, TOWN | OR LOCAT | TION | | | | | 10d. INSIDE CITY |
| DIRECTOR | MARYLAND | ALL | EGANY | | | UMBE | | | | | LIMITS? | | |
| AL | | | | | | | | | | | | | |
| FUNERAL | 531 HENDERSON AVE 21502 U.S.A. | | | | | | | Α. | | | | | |
| N | 11. MARITAL STATUS | | 12. WAS DECEDEN | YES 2 1 | MED | | | | | IIC ORIGIN? (Specify Ye | s or No- | 14. RACI | E — American Indian, k, White, etc. |
| BY F | 1 Never Married 2 | | | | 10 | | | 2 NO | | n, Puarto Rican, etc.) | | Spec | |
| ED B | | EDENT'S EDU | U.S.ARM | | | | | • | | | | | WHITE |
| | (Specify onl | y highest grade | completed) | (G | CEDENT'S live kind of v Do NOT us | vork done | during mo | ost of worki | ng | 16b. KIND OF BU | ISINESS/IN | IDUSTRY | |
| 7 | Elementary/Secondary (0 | F-12) | College (1-4 or 5 | +) | TODI | | СНОО | L SY | STEM | CUSTO | DIAN | | |
| E COMPLET | 17. FATHER'S NAME (First, M | | | | | | | | | ME (First, Middle, Maiden | | | |
| 111 | WILLIAM E | DWARD 1 | KEMP | | | | | ANN | E EL | IZABETH DE | ETZ | | |
| TO B | 19a. INFORMANT'S NAME (| ype/Print) | | | | | | | | Route Number, City or Tox | | | 100 |
| 2 - | JUNE KEMP | | | 5 | 31 H | ENDE: | RSON | AVE | . CUI | MBERLAND M | LARYL | AND | 21502 |
| examiner must be notified TO BE | 20a. METHOD OF DISPOSIT 1 Burlal 2 Crematic | on 3 🗌 Rame | ovel from State | 20b. PLACE | AND DATE (| or DISPOS | SITION (No | ODX | ATTO: | DATE 20c. LO | CATION - | - City or To | wn, State |
| | 4 Donation 6 Other | | Passes | COMBE | KLANI | | | | | 18 1995 CU | | LAND | MARYLAND |
| | MERRITT-ADAMS FUNERAL HOME | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate | | | | | | | | ARYLAND | | | | |
| E Dedical | 23. PART I. Enter the di shock, or h | iseasea, or č eert fallure. I | complications the | it coused the de use on each line | ath. Do n | ot enter | the mo | de of dy | ing, auct | h aa cerdiec or reap | iratory a | rrest, | Approximate Interval Between |
| E all | IMMEDIATE CAUSE (Fir disease or condition | nal | | 0 | 7 | .1 6. 1 | 100 | , A. | .4 | A 7 | | | Onset and Death |
| event, 1 | resulting in death) | → , | Com | (A) (OR AS A CONSE | me | iws | rull | U | Nex | 9 | | | ununm |
| | | _ | 002 10 | (OH AS A CONSE | DUENCE OF | -): | | | | | | | |
| CERTIFICATION | Sequentially list condition if any, leading to imme | | DUE TO | (OR AS A CONSEC | DUENCE OF |): | | | | | | | |
| S | Cause. Enter UNDERLY | ING | G | | | | | | | | | | |
| TIFIC | that initiated events resulting in death) LAS | | DUE TO | (OR AS A CONSE | DUENCE OF | ·): | | | | | | | |
| E E | | | d | | | | | | | | | | |
| 799 | PART II. Other algorifice | nt condition | s contributing to | death but not r | eaulting i | n the ur | derlyln | g ceuse | given in i | Part I. 24s. WAS AN | | 24b | . WERE AUTOPSY FINDINGS |
| | | | | | | | | | | PERFO | 34 | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| SHOWS | | | | | | | | 1 | | | 7 | | OF DEATH? |
| AN: 1 | DID TOBACCO U | SE CONTI | RIBUTE TO CA | USE OF DEA | TH YE | S 🔲 i | NO L | UNC | ERTAIN | 4 D | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | D MEDICAL | HOPPITAL: | 28. PLAC | E OF DEAT | H (Check | | | | | | | |
| YS! | 1 TYES 2 THO | | 1 Xinpatient 2 | ER/Outpatient 3 | □ DOA | | | e 5 □ Ri | asidence | 6 Other (Specify) | | | |
| | 27. MANNER OF DEATH | Pending | 28a. DATE OF (Month, D | | 28b. TIMI | E OF URY | _ | RK? | | 26d. DESCRIBE HOW | INJURY OC | CURED | |
| | Accident | Investigation | 28a PLACE C | OF INJURY — At ho | me term e | dragt fact | | ES 2 | NO | PALL DOLLING | | | |
| COMPLETED | | Could not be detarmined | building, | etc. (Specify) | , | meet, raci | ory, orne. | | | 281. LOCATION (Street City or Town, State, | and Numbe | IF OF HUNBI F | nouse number, |
| | 29a. CERTIFIER | IFYING PHYSIC | CIAN: To the best of | my knowledge, de | ath occurre | d at the t | Ime data | and place | and thus | to the cause(s) and me | | d-d | |
| N N | | | | | | | | | | | | |) and menner as stated. |
| | 29b. SIGNATURE AND TITLE | | | | | | | | ENSE NUM | | | | (Month, Day, Year) |
| | M. mcc | ulln | 41 41 |) | | | |) | 44 | 712 | ▶ A | ugus | t 18, 1995 |
| 2 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAU | SE OF DEATH (ITE | М 27) (Туре, | Print) | | | | | | | - |
| | N.H/Cullou | al 90 | 2 SUT | n My | Cu | nh | Mar | na | , MA | 2/502 | | | |
| | 31. DATE FILED (Month, Day, | | 32. RAGISTRA | S SIGNATURE | 1.11 | | | | 1 | - 1 | - | | |
| | AUG1 | 8 1995 | June | N. MIDNINGS | HANNEY. | | | | | | | | |



Dr.

William Lamm,

31. DATE FILED (Month, Day, Year) AUG 2 8 1995

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

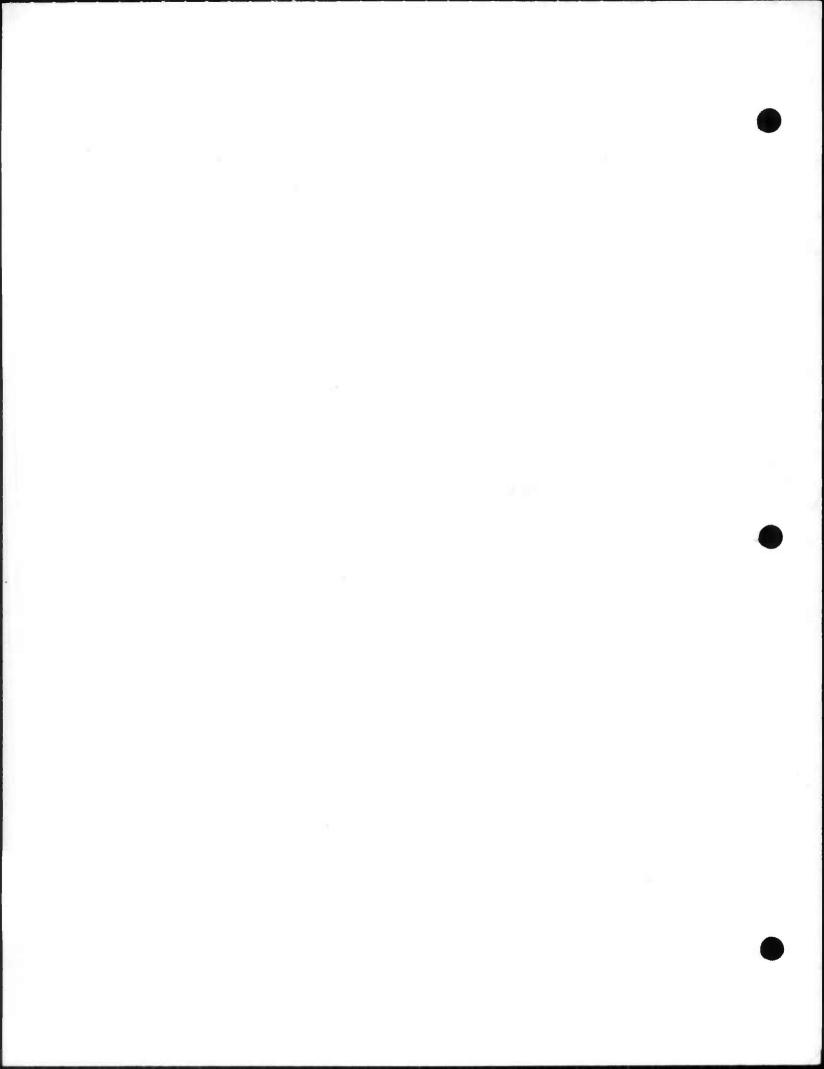
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | 35 | 274 | 45 |
|--------------------|--------------------------------------------------------------------|---------------------------------------|--------------------|------------------|----------------|-------------|---------------------------|---------------------|---------------------------------------------|-------------|-------------------|------------------------------------|---------|
| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND C | / DEPAR | TMEN' | T OF H | DEATI | AND N | MENTAL HYGIEN | | | | |
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | · | | 2. DATE OF DEATH | | | 3. TIME OF DE | ATH |
| 10 | CAROL | J | | KEI | RNS | | | | August 2 | AY 4. 1 | 995 | 8:40 | Рм |
| 11 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. la | st birthday) | IF UNDER | 1 YEAR | IF UNDER 24 | 4 HRS. | 7. DATE OF BIRTH | ., _ | 8. BIRTI | IPLACE (State or | _ |
| | 234-68-9498 | 1 ☐ M 2 💢 F | 51 | YRS. | MONTHS | DAYS | HOURS | MIN. | Dec 14, 19 | 143 | Count | WV | |
| | 90. FACILITY NAME (If not institution, give a | treet end number) | | | 9b. CITY | . TOWN | OR LOCATION | | | - | UNTY OF D | | |
| DIRECTOR | MEMORIAL HOSPITAL | | | | | BERI | | | | | LEGAN | | |
| E C | 10e. STATE 10b. COUNTY | , | | 10c, CIT | Y, TOWN (| OR LOCAT | HON | | | | | 10d, INSIDE CIT | PV |
| E | MD Alled | Allegany | | | berl | | | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | jury | | 1 Cui | mer 1 | | . ZIP CODE | | | 1 | | 1 TES 2X | |
| FUNERAL | 10706 17-11 | , | | | | | | | | US. | | WHAT COUNTRY? | |
| 2 | 12706 Valley Road | | | | | | 1502 | | | | | | |
| 5 | 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | YES 2 | NO NO | 13. | WAS DEC | ENDENT OF ecify Cuban, | HISPANII Mexican | C ORIGIN? (Specify Yes, Puerto Ricen, etc.) | or No- | 14. RACE Black | E — American Inc k, White, etc. | dlen, |
| BY | 3 Wildowed 4 Divorced | IF YES, GIVE V | MAR OR DATES | | | 1 TYES | 2 X NO | Specify: | | | Speci | | |
| | 16. DECEDENT'S EDUC | CATION | 140.00 | ECEDENT'S | I I O | COLIDATIO | NA. | | 200 000-0-100 | | | white | |
| COMPLETED | (Specify only highest grade | completed) | (0 | Sive kind of a | work done | during mo | at of working | | 16b, KIND OF BUS | SINESS/II | IDUSTRY | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5 | *7 | | | | | | | | | | |
| Z | 17. FATHER'S NAME (First, Middle, Last) | | HC | mema | ker | | | | Own Ho | | | | |
| | | | | | | | | | IE (First, Middle, Meiden | , | | | |
| BE | Charles R. Fie | Id | | | | | | _ | F. (Neff | | | | |
| 5 | 19e. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS | S (Street a | nd Number or | r Rural Ad | oute Number, City or Town | n, State, 2 | (ip Code) | | |
| - | Russell G. Kerns | | 12 | 2706 | Valle | ey R | oad; | Cumb | perland, M | D 2 | 21502 | | |
| | 20a. METHOD OF DISPOSITION 2 Buriel 2 Cremetion 3 Ramo | wel from State | 20b. PLACE | AND DATE | OF DISPOS | | | | | | - City or To | wn, State | |
| - 1 | 4 Donation 5 Other (Specify) | over moin state | Mount | . Unic | on Ce | emet | erv | | 08/27 Sla | nes | ville | , WV | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 2 722 2. 7 | 11 | 22. | NAME AN | D ADDRESS | | | | | | |
| 1 | Name 7 | 0/100 | · 11 | // | | | | | eral Home | | | | |
| | 22 PART I February to discourse | N CCC | Speu | 10 | C | mbe: | rland | , MD | 21502 | | | | |
| | 23. PART I. Enter the diseases, or c shock, or heart failure. I | omplications the List Dnly Dns cet | t caused the de | eath. Do r e. | not enter | the mo | de of dying | g, auch | as cardiac or respi | ratory a | rreet, | Approxin | |
| | IMMEDIATE CAUSE (Finel | | | | | | | | | | | Onset sr | |
| 1 | disease or condition resulting in desth) | Astro | cytoma (| Brain | n) | | | | | | | 18 | Mo. |
| | | DUE TO | (OR AS A CONSE | QUENCE O | F): | | | | | | | | |
| z | | i | | | | | | | | | | | |
| 임 | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury | | | | | | | | | | | | |
| E | that initiated events | DUE TO | (OR AS A CONSE | OUENCE OF | F): | | | | | | | | |
| E | resulting in death) LAST | ı | | | | | | | | | | | |
| | PART II Other significant condition | a contribution to | death but and | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions | contributing to | destri but not | gniyiuser | in the un | aeriying | g ceuse giv | en in P | art I. 24a. WAS AN PERFOR | | 24b. | AMILABLE PRIOF | |
| ă | - | | | | - | | | | 1 [] YES 2 | NO | | OF DEATH? | CAUSE |
| M | | 1 U YES 2 NO | | | | | | | | | | | |
| ż | DID TOBACCO USE CONTR | IBUTE TO CA | USE OF DEA | ATH YE | S 🗆 I | VO D | UNCE | RTAIN | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLAC | CE OF DEAT | | | | | | | | | |
| S | 1 TES 2 NO | HOSPITAL: | ER/Outpetlent 3 | □ DOA | OTHER 4 Num | | o 5 ☐ Rasio | dence 6 | Other (Specify) | | | | |
| ξI | 27. MANNER OF DEATH | 28e. DATE OF | | 28b. TIM | E OF | 28c. INJ | JRY AT | | 28d. DESCRIBE HOW II | NJURY O | CCURED | | |
| | 1 Natural 5 Pending | (Month, D | ey, rour) | INJ | URY | 1 Y | PK7 'ES 2 🗌 I | NO | | | | | |
| B S | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE O | F INJURY At he | ome, farm, a | rtreet, fact | ory, office | | | 281. LOCATION (Street a | nd Numbi | or Augul A | loute Number | |
| | 4 Homicide determined | building, | atc. (Specify) | | | | |] | City or Town, State) | | marrarist | | |
| COMPLET | 29a. CERTIFIER | | | | | _ | | | | | | | |
| d N | (Check only CERTIFYING PHYSIC | | | | | | | | the cause(s) and man | | | | |
| ō I | 2 MEDICAL EXAMINER | t: On the besis of e: | camination end/or | investigatio | n, In my o | pinion, de | eath occured | at the th | me, date end place, and | d due to i | the cause(s |) and manner es | stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 5 | | | | | 29c. LICENS | SE NUMB | ER | 29d. DA | TE SIGNED | (Month, Day, Year) |) |
| | Willaun | Tu | m n | W | | | D | 2540 | 06 | > | Augus | t251 | 995 |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO | COMPLETED ONLY | - W W " V | | | | | -510 | | | | x | 111 |

47 Virginia Avenue, Cumberland, MD

DHMH-16 Ray 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. 2, 3 should

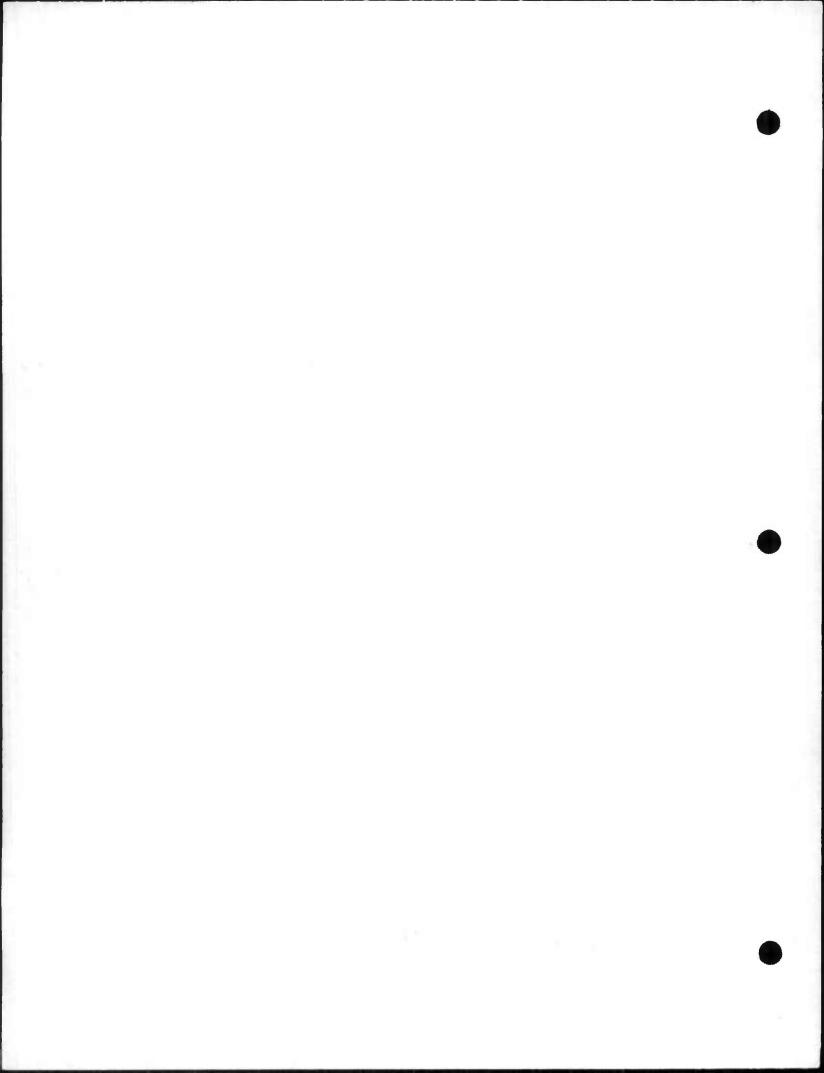
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

31. DATE FILED (Month, Day, Year)

AUG 3 0 1995

32 REGISTRAR'S SIGNATURE

| | 2 | , | / | | | | 90 | 2/446 | | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|--|
| | 1 - STATE REGISTRAR | TATE OF MARYL | AND / DEPAR CERTIF | RTMENT OF I | DEATH AND | MENTAL HYGIE REG. NO | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | VIRGINIA CATI | HERINE LY | ONS | | | August : | 29 1995 | 7:50 A M | | |
| | 3-15-44-5075 | SEX 6. AGE | (In yrs. lest birtnday) 92 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) NOV 8 1 | a. 8 | HRTHPLACE (State or Foreign country) | | |
| | 9a. FACILITY NAME (If not institution, give street a | and number) | 32 | 9b. CITY, TOWN | OR LOCATION OF D | | 9c. CDUNTY | MD DE DEATH | | |
| TOR | Solomons Nursing (| Center | | Sc | lomons | | | Calvert | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | Calvert | 10c. CIT | Y, TOWN OR LOCA SOLOTT | | | 10d, INSIDE CITY LIMITS? 1 YES 2X NO | | | |
| FUNERAL | 100. STREET AND NUMBER 13325 Dowell Road | | | 10 | 1. ZIP CODE 20688 | | OF WHAT COUNTRY? | | | |
| BY FUN | 1 Never Married 2 Married | U.S. ARMED 2 NO ATES | II yes, sp | CENDENT OF HISPAI lecity Cuban, Mexico 3 2 NO Specifi | NIC ORIGIN? (Specify Youn, Puerto Rican, etc.) by: | es or No — 14. I | RACE — American Indian, Black, White, etc. Specify: White | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of th | DN ploted) illege (1-4 or 8 +) | 16a. DECEDENT'S (Give kind of v life. Do NOT us | USUAL OCCUPATI work done during ma se retired.) | ON ost of working | 16b. KIND OF BI | USINESS/INDUST | | | |
| MP | 5 | Housev | vife | | Own | Home | | | | |
| BE CO | | | | | | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) 19b. MAJLIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | |
| | 7445 Briscoe Turn Road Owings, MD 20736 | | | | | | | | | |
| | 29e. METHOD OF DISPOSITION 1 1 Surfel 2 Cremetion 3 Removal (4 Donation 8 Other (Specify) | from State Cen | PLACE AND DATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STA | of disposition (National Place), Cemetery | 8-31-9 | | ocation - city on tingtow | | | |
| | 21. SIGNATURE OF FUNERIAL SERVICE LISTENSE | 1 PH | | 22. NAME A | ND ADDRESS OF FA | CILITY | | | | |
| _ | 110 c Uprehau | 1 1 10 | b-o | Rausc | n Funera | I Home, PA | 1 Owing | s, MD 20736 | | |
| | 23. PART I. Enter tha diseases, or comp shock, or heart fallure. List IMMEDIATE CAUSE (Final | only one cause on e | nch line. | | | | piratory arrest, | Approximate Interval Between Onset and Death | | |
| | disease or condition resulting in death) a | DUE TO (OF AS A | CONSEDUENCE OF | ry 7 | Taclu | re | | 5 min | | |
| NOIT | Sequentially list conditions, if any, leading to immediate | Uro | SUN SU CONSEQUENCE OF | 1 | | | | Iday | | |
| S | CAUSE (Disease or Injury | B115 00 100 100 10 | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DOE TO (OR AS A | CONSEDUENCE OF | F): | | | | | | |
| T. 1 | PART II. Other algolificant conditions co | ntributing to death b | ut not resulting i | n the underlyin | a cause alven la | Part I. 24a, WAS AI | u aumoney | AL MERE ALERANA EMPLIA | | |
| PHYSICIAN: MEDICAL | Seizures | | | | 9 0000 910011 111 | | RMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| N. | DID TOBACCO USE CONTRIBU | JTE TO CAUSE O | F DEATH YE | S NOY | UNCERTAII | <u>-</u> - | | 1 YES 2 ND | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE DF DEAT | | | | | | | |
| YSI | 1 YES 2 XND 1 | Inpatient 2 - ER/Outp | atient 3 DOA | 4 Nursing Hom | e 5 🗆 Residence | 8 🗌 Other (Specify) | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIMI | URY WO | URY AT PRK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURE | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE DF INJURY building, atc. (Spec | — At home, farm, a | street, factory, offic | | 281. LOCATION (Street City or Town, State | | rel Route Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On | | | | | | | se(s) end manner as stated. | | |
| E CC | 29b. SIGNATURE AND TITLE OF CERTIFIER | 17 | , | | 29c. LICENSE NUM | | | | | |
| 0 | Susant. | Krow | | | D)<72 | 31 2967 | > (de | WED (Morith, Day, Year) | | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO COI | MPLETED CAUSE OF DEA | ATH (IPEM 27) (Type, | Print) | 700 | VI OH -11 | 6 | 70,176 | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

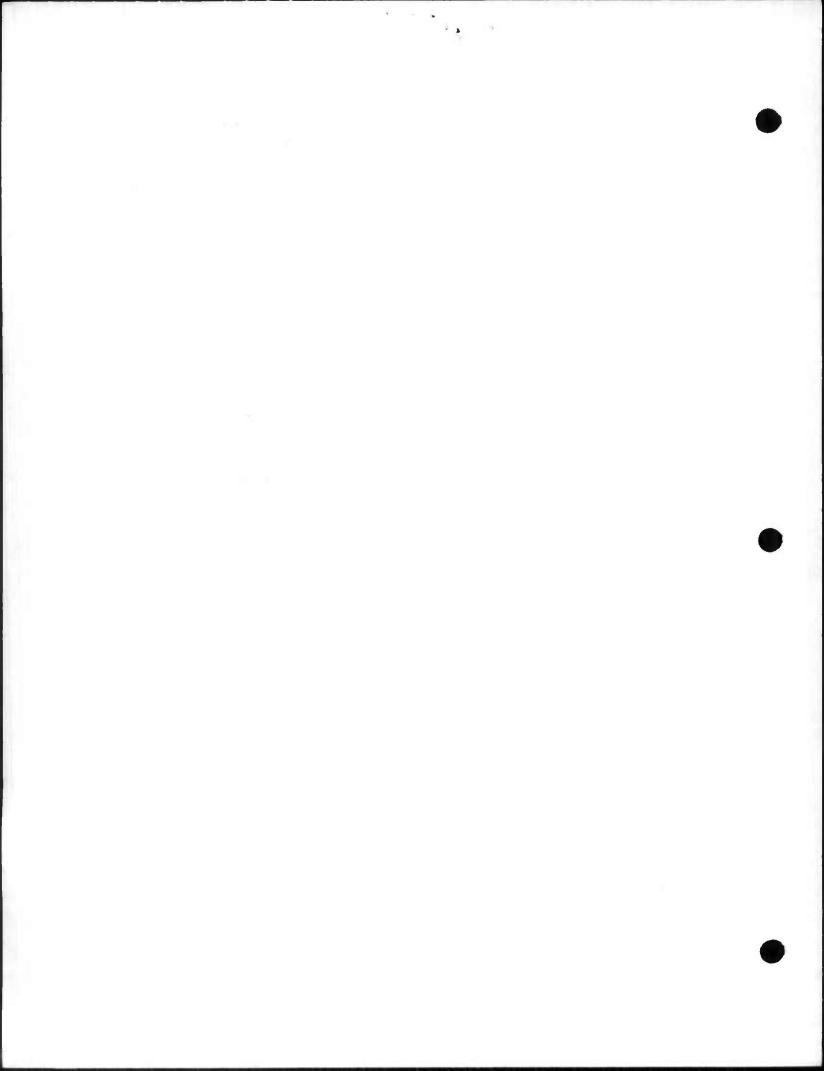
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hiter death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPURIANT I NEW 28 IS MATED, OF NEW 23 Shows any Injury, of other traumatic event, the medical examiner must be notified at once. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN | | | |
|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------|----------------------------------------------------------|-------------------------------------------------|---------------------------------------|-------------------------------------------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) Edith | n Palmer | Love | | | 2. DATE OF GEATH WONTH AUGUST I | | 3. TIME OF DEATH 0245 | |
| | 4. SOCIAL SECURITY NUMBER 214-07-7630 | 1 M 2 X F 96 | YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS, HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) July 31 18 | Cou | THPLACE (State or Foreign ritry) Iryland | |
| TOR | 99. FACILITY NAME (If not institution, give s Simms Care Ho RESIDENCE OF DECEDENT | | | | ridge | EATH | Dorches | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | chester | 10c. CITY, | Cambrid | | | 10d. INSIGE CITY LIMITS? 1 YES 2 X NO | | |
| FUNERAL | 100. STREET AND NUMBER 5502 Mallard | Lane | | 10f. | ZIP CODE 216 | 513 | 10g. CITIZEN OF | WHAT COUNTRY? | |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2XXNO | If yes, spe | ENOENT OF HISPAI celfy Cuben, Mexica 2XXNO Specifi | NIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.) | Bia | CE — American Indian, lick, White, atc. | |
| COMPLETED | 15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | life. Do NOT use | rk done during mos | N st of working | 16b. KINO OF BUS | SINESS/INOUSTRY | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Thomas | s J. Palmer | | | | ME (First, Middle, Melden Annie Ste | Sumame) Vens | | |
| TO B | | | | | | | | | |
| | 20e. METHOO OF DISPOSITION 1 \(\text{S}\) Burlel 2 \(\text{Cremation} \) 3 \(\text{Remote}\) Remote 4 \(\text{Donetion} \) 5 \(\text{Other (Specify)} \) | ovel from State La | PLACE AND DATE OF BIENY, COMPARTORY OF SHIP ST NEW ME | arket Ce | emetery | 8/22 East | cation—city or t New Ma | Town, State rket Md. | |
| | Thomas Funeral Home 700 Locust St. Cambridge MD 21613 | | | | | | | | |
| NO | 23. PART I. Enter the diseases, or a shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | OUE TO (OR AS A | the death. Do no not line. Dobit CONSEQUENCE OF): CONSEQUENCE OF): | | . 4 | | ratory arreat, | Approximate Interval Between Onset and Death | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | c | CONSEQUENCE OF): | | | | | ľ | |
| MEDICAL | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PREPORMED? | | | | | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| PHYSICIAN: | DID TOBACCO USE CONTE | | 6. PLACE OF OEATH | | UNCERTAIN | N 🗆 | | | |
| PHYSI | 1 TYES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Output 28e. OATE OF INJURY (Month, Day, Year) | | Nursing Home | JRY AT | 6 Other (Specify) 28d. OESCRIBE HOW II | NJURY OCCUREO | | |
| ED BY | 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — At home, farm, str | | ES 2 NO | 261. LOCATION (Street e City or Town, State) | and Number or Rura | Floute Number, | |
| COMPLETED | 29e. CERTIFIER (Check only one) | CIAN: To the best of my knowle | edge, death occurred | at the time, date | and place, and due | to the cause(s) end man | ner as stated. | | |
| BE CO! | 2 MEDICAL EXAMINED 296. SEGNATURE AND TITLE OF CERTIFIER | R: On the basis of exemination | end/or Investigation, | In my opinion, de | 29c. LICENSE NUM | | | (e) and menner ee stated. O (Month, Day, Year) | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | 12. 12. 11 | | hurra | V-28 | 209 amb-10 | MIS | 20, 1995 | |
| | 31. DATE FILEO (Month, Day, Year) AUG 2 4 19 | 95 James Williams | | | 77 | and fe | 19 | -14/5 | |

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | REGISTRAR | | CERTIF | ICALE | OF DEA | H | REG. NO |). | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------|--------------------------------------------|---------------------------|------------------|------------------------------|----------------------|-------------------------------------------------|-------------|-------------------|-------------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) JOHN J. | LUBSA | TIME | | 47 | | 2. DATE OF DEATH | 2 | YEAR 995 | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. last birthday) | IF UNDER 1 Y | EAR IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | a. BIRTHE | LACE (State or Foreign |
| | | 214-03-0884 | 17☑ M 2 🗍 F | 77 YRS. | MONTHS D | AYS HOURS | MIN. | Aug 23, 1 | 017 | Country | ryland |
| pino | | 9a. FACILITY NAME (If not institution, give st | | 9b. CITY. TO | WN OR LOCATION | ON OF DE | | 7 | INTY OF DE | - | |
| 2, 3 should | Œ | Howard County Gen | | | Colu | | 011 01 01 | Salin | | ward | nin . |
| 1, 2, | 18 | RESIDENCE OF DECEDENT | CLUI | | COLU | пыта | | | 110 | waitu | |
| Seg | DIRECTOR | 10a. STATE 10b. COUNTY | , | 10c. CI | TY, TOWN OR I | OCATION | | | | | 10d. INSIDE CITY |
| £. | <u> </u> | Maryland Ho | ward | 1 | Ellico | tt City | 7 | | | | LIMITS? |
| permit. Pages 1, | AL | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | E | 10g. CITIZEN OF | | | IAT COUNTRY? |
| TS. | FUNERAL | 3124 Old Fence Ro | ad | | | 210 |)42 | | U | nited | States |
| physician. burial-transit | 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | 13. WAS | DECENDENT O | F HISPAN | IIC ORIGIN? (Specify Ye | s or No- | 14. RACE - | - American Indian, White, etc. |
| | | 1 Never Married 2 Married | FORCES? 1 7 YES | | If ye | YES 2 NO | n, Mexica Specifi | n, Puerto Rican, etc.) | | Black, Specify | |
| ending as the | ВУ | 3 Widowed 4 Divorced | W | II | | | , | | | 4,000,000 | White |
| or attending r use as the | ED. | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DECEDENT'S | USUAL OCCU | IPATION ng most of workin | 107 | 16b. KIND OF BU | SINESS/IN | DUSTRY | |
| | LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Illin. Do NOT u | se retired.) | | | | _ | | |
| the hospital or atti detached for use once. | ₽ D | 12 | | Super | rvisor | | | Feder | al G | overme | ent |
| detach | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | | ME (First, Middle, Maiden | Sumame) | | |
| d by | BE | | rtine | | | Ca | ther | rine | Star | _ | |
| 5 should | 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or Tox | | | |
| | - | Ida V. Lubertine | | 312 | 4 Old 1 | Fence F | load | Ellicott | City | MD 2 | 21042 |
| f, page | | 20a. METHOD OF DISPOSITION 1.X Burial 2 Cremation 3 Ramo | | D. PLACE AND DATE | OF DISPOSITIO | N (Name of | | | 100 | City or Tow | |
| rector, present | 1 | 4 Donation 5 Other (Specify) | Ce | Sacred He | eart o | f Jesus | 5 | 8-25 Du | ndall | c, Mai | ryland |
| ral di | | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | 22. NAI | E AND ADDRES | S OF FA | CILITY | | | |
| hours after death, Page 6 may ed in by the funeral director, pa or removal. medical examiner must b | | Harry H. Witzke Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City21043 | | | | | | | | | |
| d in by the or removal. | | 23. PART I. Enter the diseases, or c | omplications that cause | ed the death. Do | not enter the | mode of dyl | ng, sucl | n as cardiec or resp | iratory ar | rest, | Approximata |
| filled in on, or n | | shock, or heart failure. I IMMEDIATE CAUSE (Final | List only one cause on | | | | | | | | Interval Between Onset and Daath |
| | | disease or condition | KESPU | 147014 | Za. | 1115 | | | | | 8/2 /00 |
| completely ial, cremati | | resulting in death) | DUE TO (OR AS | A CONSEQUENCE O | f): | 20/00 | | | | | 0/11/33 |
| | z | | HEUTE | A CONSEQUENCE OF | LIDIA | Tres | TAN A. | 7.2 | | | 8/21/95 |
| n and to bur | CERTIFICATION | Sequentially list conditions, if any, leading to immediate | | A CONSEQUENCE O | F): | | 1114 | 1,00 | | | |
| physician ne prior t | 8 | cause. Enter UNDERLYING CAUSE (Disease or injury | HTHEN | WSCENO | 2 4 | | | | | | TRS |
| rtificz g ph jene jene | 드 | that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | |
| endin Hyg | 띮 | resulting in death) LAST | | | | | | | | | |
| death demta | | DART II Other significant and distant | | | | | | | | | |
| by the | EDICAL | PART II. Other aignificent conditions | - 6/AU/ | but not resulting | in the under | riying cause g | iven in | Part I. 24s. WAS AN PERFOI | | | VERE AUTOPSY FINDINGS |
| alth and | ă | | | > | | | | 1 YES : | 200 | | COMPLETION OF CAUSE OF DEATH? |
| equin | Z | DEMENTA | | | | | | _ ^ | | 1 | YES 2 NO |
| law n is be ept. | PHYSICIAN: | DID TOBACCO USE CONTR | IBUTE TO CAUSE (| OF DEATH Y | S NC | ☐ UNC | ERTAIN | 1 🗆 | | | |
| The harte ha | S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | | one) | | | | | |
| TITIFICATION STATE OF 18 | YSI | 1 🗆 YES 2 🗇 6 | | tpetient 3 🗆 DOA | OTHER: | Home 5 - Re | aldence | 6 Other (Specify) | | | |
| HYSIC is ce ith th | H | 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIN | E OF 260 | : INJURY AT WORK? | | 28d. DESCRIBE HOW I | NJURY OC | CURED | |
| IG Pi | BY | Netural 5 Pending Investigation | | | | YES 2 | NO | | | | |
| R: At er de | | 3 Suicide 6 Could not be | 28e. PLACE OF INJUR building, atc. (Spi | Y — At home, farm, | street, factory, | office | | 281. LOCATION (Street : City or Town, State) | and Number | or Rural Roo | ite Number, |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate It or THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physic be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pric IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other tra | E | 4 Homicide determined | | | | | | ony or nown, orano, | | | |
| Piour Pour | MPLET | 29a. CERTIFIER CERTIFYING PHYSIC | IAN: To the best of my know | wledge, death occurr | ed at the time, | date and place, | and due | to the cause(s) and mai | nner as sta | led. | |
| ERAL FILL FILL FILL FILL FILL FILL FILL FI | ŏ. | | : On the besis of examinati | | | | | | | | end manner as stated. |
| NE NE NE | O | 296. SIGHETURE, AND THE GENCERTIFIER | | | | | NSE NUM | | - | 1 | |
| 물 물을 2 | # H | HAR Va | 1 | | | Tous | 3 11 | 77/ | A C | P C | fonth, Dfy, Year) |
| F 5 8 5 | 유 | 30, NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF D | EATH (ITEM 97) (Free | Print) | | J + (| (" | | 10. | 3/13 |
| | | HA OKEN ME | 344 A I | | | D | To. | | N | 0.3 | 640 |
| 2 | 1 | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | MCETT (| -127 EV | 1-1 | Du | (417 47 | 417 | 04 | 644 |
| 6 | | AUG 2 5 1995 | Julia d'Avulsa | rhardell | | | | | | | |

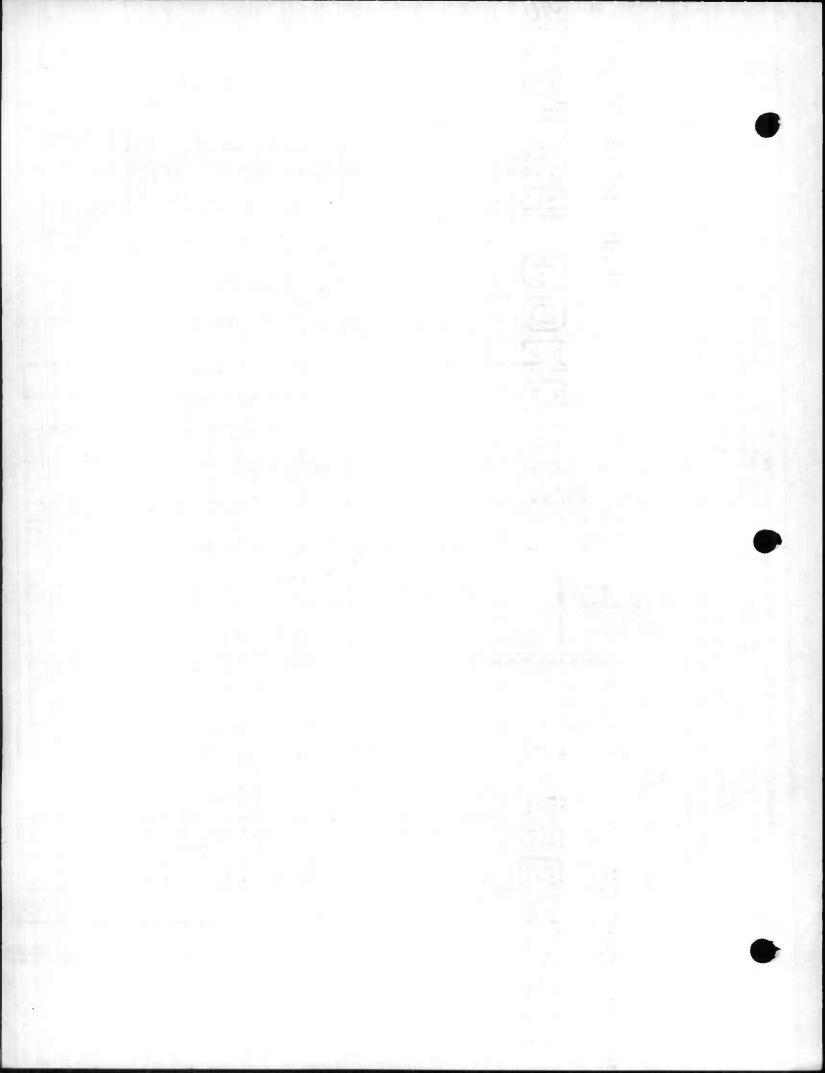


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| TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within whours after death. Page 6 may be retained by the hospital or attending physician. | VAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, | 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, | |
| TENC | DR: | fler (| |
| A AL | RECT | MS a | |
| 0 | 10 | Phot. | |
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| | REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATI | | | | 2 DATE OF | REG. NO. TE OF DEATH 3. TIME OF DEAT | | | | | |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------|--|--|
| | Jeanie P. Lancaster | | | | | MONTH | t 22, 1995 | YEAR | 5:15 P. | | |
| t | 4. SOCIAL SECURITY NUMBER | | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | S. BIRTHPLA | CE (State or Foreig | | |
| | 217-03-2027 DB. FACILITY NAME (If not institution, give | 1 D M 2 DF 88 | YRS. | MONTHS DAYS | HOURS MIN. | May 12 | 2, 1907 | Maryl. | and | | |
| | Egle Nursing Home | | | Lonacon | | | | | | | |
| | 10a. STATE 10b. COUN | | | Y, TOWN OR LOCAT | TION | 10d. INSIDE CITY | | | | | |
| | Maryland Allegany | | | Lonaconing | | | 1 | | LIMITS? | | |
| | 10. STREET AND NUMBER 10 A Beechwood Street | | | 101. ZIP CODE 21539 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 32 NO | | | | | | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 6 +) HOMEM | | | rork done during most of working | | | KIND OF BUSINESS/INDUSTRY Home | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Andrew Steele | Sr. | • | | 18. MOTHER'S N | | Idle, Maiden Surname) | | 1.0 | | |
| | 100. INFORMANT'S NAME (Type/Print) Imogene Stafford | | | | | | city or Town, State, Zip | | | | |
| 1 | Imogene Stafford 32 Beechwood St., Lonaconing, Md. 21539 20a. METHOD OF DISPOSITION 1 St Burlal 2 Cremation 3 Ramoval from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE DISPOSITION (Name of Campiery, Cremation of Oak Hill Cemetery August 26, 1995 Lonaconing, Md. | | | | | | | | | | |
| 3 | 21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY Eichhorn—McKenzie Funeral Home Lonaconing, Md. 21539 | | | | | | | | | | |
| | 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heer feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Chookie Reval Failure 1 141. | | | | | | | | | | |
| | Sequentielty list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c. | | | | | | | | | | |
| | CAUSE (Disease or injury | DUE TO (OR AS | resulting in death) LAST | | | | | | | | |
| | CAUSE (Disease or injury that initiated events | d. | | | | | | | | | |
| | CAUSE (Disease or injury that initiated events | d, | but not resulting i | in the underlyin | g cause given in | | 4s. WAS AN AUTOPSY PERFORMED? YES 2 NO | AVA COI OF | ILABLE PRIOR TO | | |
| | CAUSE (Disease or injury that initiated events resulting in death) LAST | ona contributing to death | but not resulting i | 26. PI | g cause given in | 1 | PERFORMED? | AVA COI OF | RLABLE PRIOR TO MPLETION OF CAUS DEATH? | | |
| | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | d. ona contributing to death HOSPITAL: 1 Inpatient 2 ER/Ou | rtpetient 3 🗆 DOA | 26. PI OTHER: 4 Nursing Horr | LACE OF DEATH (C | theck only one) | PERFORMED? YES 2 NO Specify) | AVA COI OF | MPLETION OF CAUS DEATH? | | |
| | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | d. One contributing to death HOSPITAL: 1 Inpatient 2 ER/Ou 29a. DATE OF INJURY (Month, Day, Year) | ripetient 3 DOA | 26. PI OTHER: 4 Nursing Hom E OF 28c. INJ. URY WC | LACE OF DEATH (C | theck only one) | PERFORMED? VES 2 NO | AVA COI OF | RLABLE PRIOR TO MPLETION OF CAU DEATH? | | |
| | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Ou 29e. DATE OF INJURY (Month, Day, Year) | ripetient 3 DOA 26b. TIMI | 26. PI OTHER: A Nursing Horr E OF 28c. INJ. URY WC M 1 1 | LACE OF DEATH (C | theck only one) 6 Other (: 28d. DESC! | PERFORMED? YES 2 NO Specify) | OF 1 CURED | ILABLE PRIOR TO MPLETION OF CAU DEATH? YES 2 NO | | |
| | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFIVNO PMY: | HOSPITAL: 1 Inpatient 2 ER/Ou 29a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Sp | ripatient 3 DOA 28b. TIMI INJI RY — At home, farm, s ecity) | 26. PI OTHER: 4 Nursing Horr E OF URY M 1 1 1 Street, fectory, officed at the time, date | LACE OF DEATH (C) to 5 Residence URY AT URY AT YES 2 NO to to end place, and du | heck only one) 6 Other (: 28d. DESCI 28f. LOCAT City or | PERFORMED? YES 2 NO Specify) NIBE HOW INJURY OCC ION (Street and Number of Town, State) | URED URED | ILABLE PRIOR TO MPLETION OF CAUNDEATH? YES 2 NO | | |
| | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFIVNO PMY: | HOSPITAL: 1 Inpetient 2 ER/Ou 29a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Sp | ripation: 3 DOA 26b. TiMi INJI RY — At home, farm, s ecity) weedge, death occurre ion and/or investigation | 26. PI OTHER: Nursing Hom E OF URY M 1 1 1 Street, factory, office ad at the time, data n, in my opinion, d | LACE OF DEATH (C) to 5 Residence URY AT URY AT YES 2 NO to to end place, and du | 28d. DESCI 28d. DESCI 28d. LOCAT City or the to the cause of time, data an | PERFORMED? YES 2 NO Specify) RIBE HOW INJURY OCCI ION (Street and Number of Yown, State) | URED OF Rural Route In Cause(s) and Signed (Mo | MLABLE PRIOR TO MPLETION OF CAUS DEATH? YES 2 NO | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, gage 5 should be detached for use as the burial-transit nermit. Pages 1 |
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| be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

31. DATE FILED (Month, Dey, Year)
JUL 51 '95

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| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAN | | TMENT OF H | | MENTAL HYGIEN | | 300 | |
| | 1. DECEDENT'S NAME (First, Middle, Lest) | 4 | | | | 2. DATE OF DEATH | 2. DATE OF DEATH | | |
| | Esther K. Marb. | | | | | 07 28 | 95 | 7:25 p M | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | yrs. lest birthdey) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | Co | RTNPLACE (State or Foreign untry) | |
| | | M 2 x F 9 | l YRS. | | | Feb. 20 | | Maryland | |
| DIRECTOR | 9a. FACILITY NAME (If not institution, give street and Caroline Nursing Hor | | | Dento | n Location of E | DEATH | Caroli | | |
| EC | 10e. STATE 10b. COUNTY | | 10c, CIT | Y, TOWN OR LOCAT | TON | | | 10d, INSIDE CITY | |
| E . | Maryland Carolin | ne | Den | ton | | | | LIMITS? | |
| AL | 10e. STREET AND NUMBER | | | | . ZIP CODE | | 10g. CITIZEN C | OF WHAT COUNTRY? | |
| ER | 520 Kerr Ave. | | | | 2162 | 9 | U. | S.A. | |
| FUNERAL | | AS DECEDENT EVER IN U. DRCES? 1 YES | S ARMED | 13. WAS DEC | ENDENT OF HISPA | ANIC ORIGIN? (Specify Veran, Puerto Rican, etc.) | | ACE — American Indian, lack, White, etc. | |
| ВУ | 3 Wildowed 4 Divorced | YES, GIVE WAR OR DATE | | | 2 NO Spec | | | pecify: White | |
| TEC | 15. DECEDENT'S EDUCATION (Specify only highest grade complete | (ed) | Give kind of | USUAL OCCUPATION work done during more retired.) | ON st of working | 16b. KIND OF BU | SINESS/INDUSTR | Y | |
| COMPLETED | Elementary/Secondary (0-12) Colleg | ge (1-4 or 5+) | teac | | | Caroli | ne Publi | c School Sys | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N | AME (First, Middle, Meiden | | o beneda bys | |
| С | John F. Kelly | | | | | nia Carter | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | nd Number or Rura | I Route Number, City or Tox | n, State, Zip Code, | 1 | |
| 5 | Jean Kelly | | | | | Greensbord | | | |
| | 20e. METHOD OF DISPOSITION 1 (X Burlet 2 Cremetion 3 Removal from | | ACEANDDATE | OF DISPOSITION (Ne | | | CATION City o | | |
| | 4 Denetion 6 Other (Specify) Concord Cemetery 7/31 Concord, Maryland | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 1 | | | D ADDRESS OF F | ACILITY | | | |
| | Muchal | - Len | 6 | Flee | gle-Hel | fenbein Fur O Greensbo | neral Ho | me vland 21639 | |
| | 23. PART I. Entar the diseases, or complic | etions that caused th | ne daath. Do r | ot enter the mo | de of dylng, su | ch as cardiac or resp | Iratory arreat, | Approximate | |
| | ahock, or heart fellure. List one | ly one ceuse on sect | ine. | 1 | | | | interval Batween Onset and Death | |
| | disease or condition - a. Cerebro vascular accident month | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Z | DUE TO (OR AS A CONSEQUENCE OF): Atrill Fibrillation | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | | | | | | | | |
| 5 | cause. Enter UNDERLYING CAUSE (Disease or Injury | DUE TO (00 40 4 00 | Marallen or or | | | | | | |
| E | that initiated events resulting in death) LAST | DUE TO (OR AS A CO | INSEQUENCE OF | -): | | | | | |
| Ü | d | | | | | | | | |
| AL | PART ii. Other algnificant conditions contr | ributing to deeth but | not reaulting i | n the underlying | ceuse given in | | | 24b. WERE AUTOPSY FINDINGS | |
| 200 | | | | | | | COMPLETION OF CAUSE OF DEATH? | | |
| ME | | | | | | | | 1 TYES 2 NO | |
| ž | | | | | | | - 1 | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | PITAL: | | | ACE OF DEATH (C | heck only one) | | | |
| YSI | 1 YES 2 NO 1 In | petient 2 - ER/Outpetie | int 3 🗆 DOA | OTHER: | 5 🗆 Residence | 6 🗆 Other (Specify) | | | |
| H | 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | |
| BY | 1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | |
| COMPLETED | 3 Suicide 6 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | |
| PE | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To | the best of my knowledg | e, death occurre | d at the time, date | and place, and du | e to the cause(s) and mai | nner ea stated. | | |
| NO | one) 2 MEDICAL EXAMINER: On the | | | | | | | e(a) and menner as stated. | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | - | | | 29c. LICENSE NU | | | IEO (Month, Day, Year) | |
|) BE | Janes Sikes 13137 17-3 LOT | | | | | | | | |
| 2 | 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | |
| | James Sides P.C | D. Box 496 | Dente | on, Mary | land 2 | 21629 | | | |

32, REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

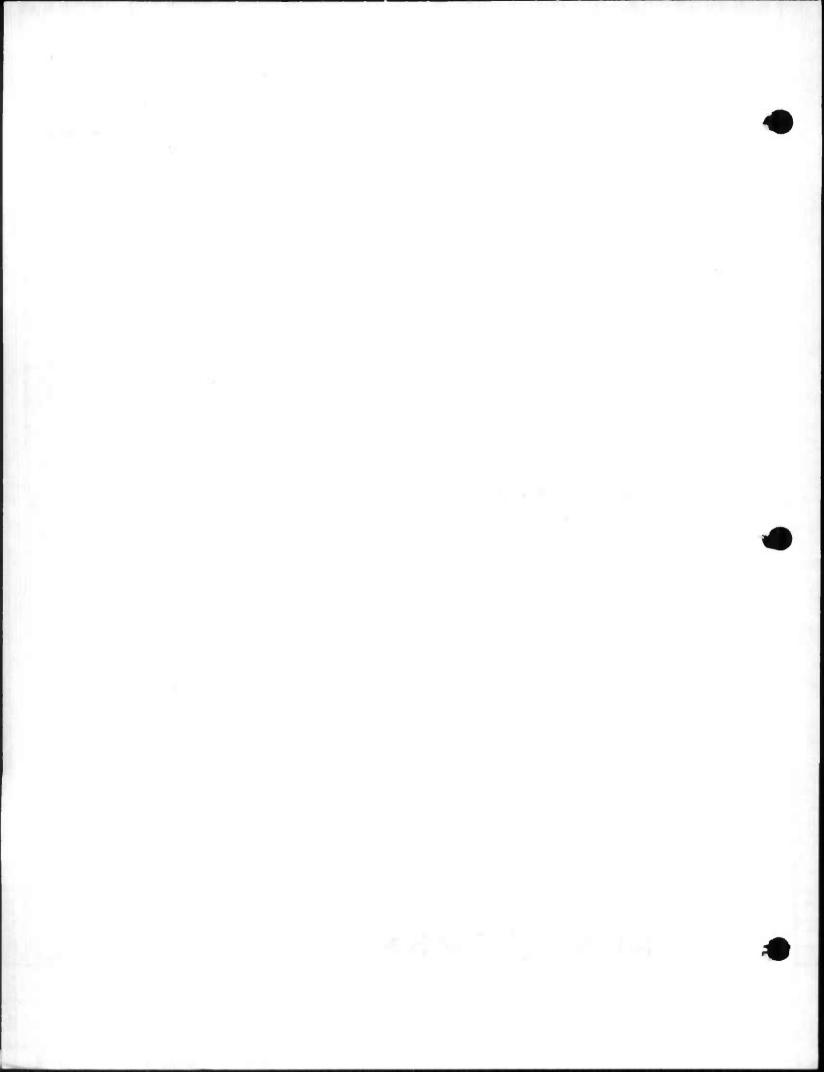
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| DIVISION OF VITAL RECORDS, P.O. | 5 |
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32. AIGISTRAR'S SIGNATURE. JUNA DAVIDSON-Randoll

| OTHE MOSFILM, OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within. Through a fire of the contribution has been signed by the attending physician. OTHE FUNEAR, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funearial director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 burial bythe prior to burial, cremation, or removal. MPORTANT: If filled 28 is marked, or filled 3 shows any injury, or other traumatic event. The medical examinar must be partitled at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | ITMENT OF I | | MENTAL HYGIEN | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) John Ma | rtin Marz | - CLITTI | TOTAL CI | DEATH | 2. DATE OF DEATH MONTH DAUGUST 13, | AY | YEAR | 2:03Pm |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In | yrs. lest birthday) 55 YRS. | IF UNDER 1 YEAR MONTHS DAYS | F UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) DECEMBER 30, | 1939 | e. BIRTNPI Country) New | Jersey |
| DIRECTOR | 27340 Redden Road | Redden Road | | | | DEATH | caroline | | |
| DIRE | 10a. STATE 10b. COUNTY Maryland Carol | - | | | TION | | Od. INSIDE CITY LIMITS? YES 2 1 NO | | |
| RAL | 10e. STREET AND NUMBER 27340 Redden Road | | 10 | 10f. ZIP CODE 21629 | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| BY FUNERAL | | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | If yes, s | B DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— sa, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE—Black, Black, Specify: Specify: | | | | | |
| COMPLETED | (Specify only highest grade co | | | | ON ost of working | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Logg | er | 18. MOTNER'S N | Logging AME (First, Middle, Melden Surname) | | | |
| BE | Martin | Marz | | | Elizabeth Hermes | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27340 Redden Road, Denton, Maryland 21629 | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Distributed 2 10 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fastern Shore Crematorium 8/14 Georgetown, Delaware | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. PO Drawer B, Denton, Maryland | | | | | | 21629 | | |
| | 23. PART i. Eriter the diseases, or conshock, or heart fall in Life Life IMMEDIATE CAUSE (Final disease or condition resulting in death) | mplications that caused at only one cause on each only one cause on each only one cause on each only one cause on each only one cause on each only one cause on each only one cause on each one cause on each only one cause on each only one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause on | Leve | Heat | de of dying, su | ch as cardlec or respi | ratory arra | et, | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A (| | / | rseal | Mary . | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PROPOSE PERFORMED? 1 YES 2 WO 1 YES 2 WO 1 YES 2 WO | | | | | | | WALABLE PRIOR TO OMPLETION OF CAUSE F DEATH? | |
| SICIAL | 25. WAS CASE SEPERIFIED TO MEDICAL EXAMPLE TO 1 | | | | | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJUSY 28b. TIME OF WORKY AT WORKY WORKY 1 YES 2 NO | | | | B ☐ Other (Specify) ZHE DESCRIBE HOW INJURY OCCURED | | | |
| 13 | 3 Suicide 8 Could not be detarmined | | | | | | r Runit Rou | te Numbec | |
| COMPLETED | | N: To the best of my knowled On the basis of examination | | | | | | | nd menner as stated. |
| O BE C | 296, SIGNATURE AND TITLE OF CERTIFIER | N// | an II. | | 29c. LICENSE NI | | | | Month, Day, Year) |

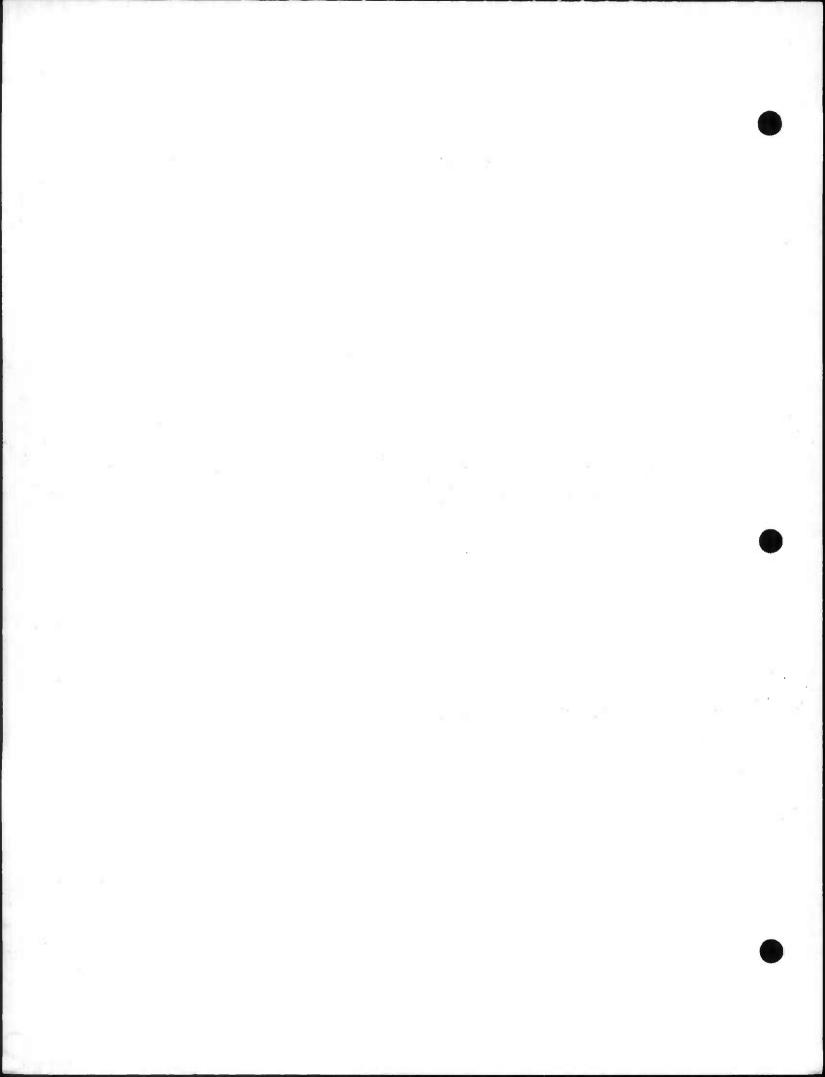


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

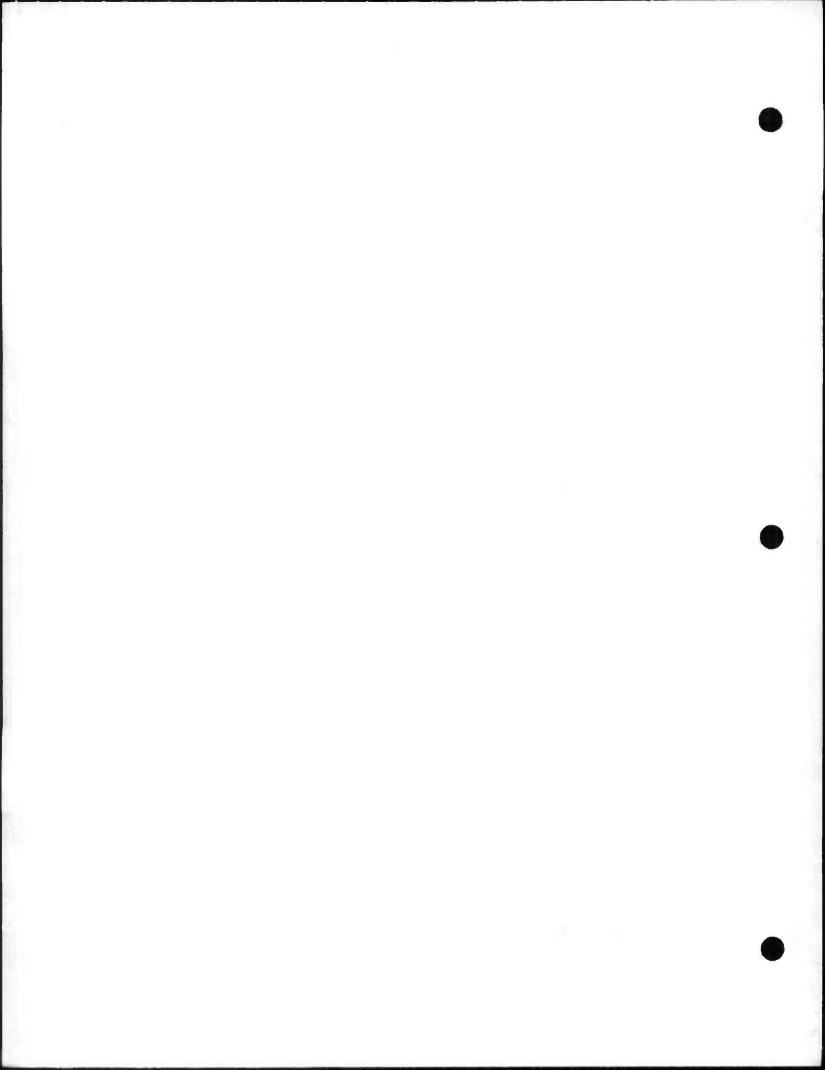
| 20 60 ~ | e law requires that the death has been signed by the atte Dept, of Health and Mental 1.23 shows any injury, c | O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a mours after of O THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the effect within 72 hours after death with the State Deor. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical expenses. | | VG PHYSICIAN: The law requires that the death certificate be executed within X nours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Defin of Health and Mental Horiene prior to burial cremation, or removal | d, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | MENTAL HYGIEN | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Marcella C. | Mullan | | | | Aug. 19, | 1995 YEAR | 4:00A M |
| | | | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | S. BIPT | THPLACE (State or Foreign |
| | 214-05-4240 9e. FACILITY NAME (If not institution, give street | M 2 XF 8 | 8 YRS. | MONTHS DAYS | PR LOCATION OF DE | (Month, Day, Year) Jun. 18, 1 | 907 Mai | rvland |
| DIRECTOR | Devlin Manor Nursi | | | Cumbe | | | Allega | |
| EC | 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWH OR LOCAL | ION | | | 10d, INSIDE CITY |
| | Maryland Alleg | any | | | mberland | | | 1 YES 2 NO |
| FUNERAL | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | | | | ZIP CODE | | | WHAT COUNTRY? |
| N. | 438 Chestnut St. | . WAS DECEDENT EVER IN | 110 401100 | | 21502 | | USA | |
| BY FU | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 TYES IF YES, GIVE WAR OR DAT | 2 XNO | If yes, sp | ecity Cuben, Mexica 22 NO Specifi | NIC ORIGIN? (Specify Yea in, Puerto Rican, etc.) y: | Rin | CE — American Indian, ck, White, etc. chy: White |
| G | 15. DECEDENT'S EDUCATI (Specify only highest grade corr | ON | 16e. DECEDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BUS | SINESS/INDUSTRY | |
| 4 | | College (1-4 or 5 +) | life. Do NOT us | work done during mo se retired.) | st of working | | | 7 |
| P | 7 | | Type Se | etter | | / Print | ing | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | Sumame) | |
| H | Robert Cunningh | am | | | | (Haldman) | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Mary Keller | | | | | Route Number, City or Tow berland, M | | |
| | 20e, METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Femoval | | | OF DISPOSITION (NO | me of | DATE 20c. LO | CATION — City or | Town, State |
| | 4 Donation 5 Other (Specify) | | tery, crematory or o | & Paul | Cemeter | y 8/21 Cum | berland, | MD |
| | 21. SIGNATURE OF FUNERAL GERVICE LICENS | | 4 | 22. NAME A | D ADDRESS OF FA | CHUTY Kight F | uneral H | ome |
| | * William | 13 Kigh | $\langle \Gamma \rangle$ | | | ır St., Cun | | |
| | 23. PART I. Enter the diseeses, pr cpm | plications that paused | the deeth. Do r | not enter the mo | de of dying, auc | h as cardiac or reepi | iratory arrest, | Approximate |
| | shock, or heart failure. List IMMEDIATE CAUSE (Fine) | Dnly one ceuse on ea | ch line. | | | | | Interval Between Onset and Death |
| | disease or condition resulting in deeth) | CL | - | Lung | Late | Pourh. | | 30 ms |
| | a | DUE TO (OR AS A | CONSEQUENCE OF | F): | 1400 | leuhene | | 1.74 |
| Z | 6 | | | | | | | |
| Ĕ | Sequentially list conditions, If any, leeding to immediate | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | | | | | | | |
| | that initisted eventa resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | |
| GE | d | | | | | | | |
| AL | PART II. Other algnificant conditions of | ontributing to deeth bu | t not resulting | n the underlyin | ceuse given in | Part I. 24s. WAS AN PERFOR | | b. WERE AUTOPSY FINDINGS |
| 5 | | | | | | 1 - YES 2 | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | 1 YES 2 NO |
| ä | DID TOBACCO USE CO | NTRIBUTE TO | CAUSE OF | DEATH Y | ES NO | B | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | | ACE OF DEATH (Ch | eck only one) | | |
| 1S | | ☐ Inpatient 2 ☐ ER/Outpe | tient 3 🗆 DOA | OTHER: | e 5 🗆 Residence | 6 Other (Specify) | | |
| F | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIM INJ | | URY AT RK? | 28d. DESCRIBE HOW I | NJURY OCCURED | |
| B | 1 Netural 5 Pending 2 Accident Investigation | | | | rES 2 NO | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY - building, etc. (Specif | — At home, farm, s | street, factory, offic | | 28t. LOCATION (Street of City or Town, State) | and Number or Rural | Route Number, |
| E | | | | | | | | |
| 립 | 29e. CERTIFIER (Check only one) | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINER: 0 | in the basis of examination | end/or investigation | n, in my opinion, o | eath occured at the | time, date and place, en | d due to the cause | (e) end menner ee stated. |
| BE | 29b. SIGNATURE AND TITLE OF | 7 0 | | | 29c. LICENSE NUI | | | D (Month, Day, Year) |
| 면 인 | Wy sele | no All | 4 | | 1017 | 565 | 1872 | 485 |
| | A-573 (11 m 4 95 | OMPLETED CAUSE OF DEAT | TH (ITEM 27) (Type. | Print) | | | | |
| | | BR. REGISTRAR'S SIGNA | | | | | | |
| | 710 0 20 1000 | | - CALLAN | | | | | |



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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 23 hours and death. Page 6 may be retained by the hospital or | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the turning completely filled in by the turning of property of the first property of the turning of property of the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the comp | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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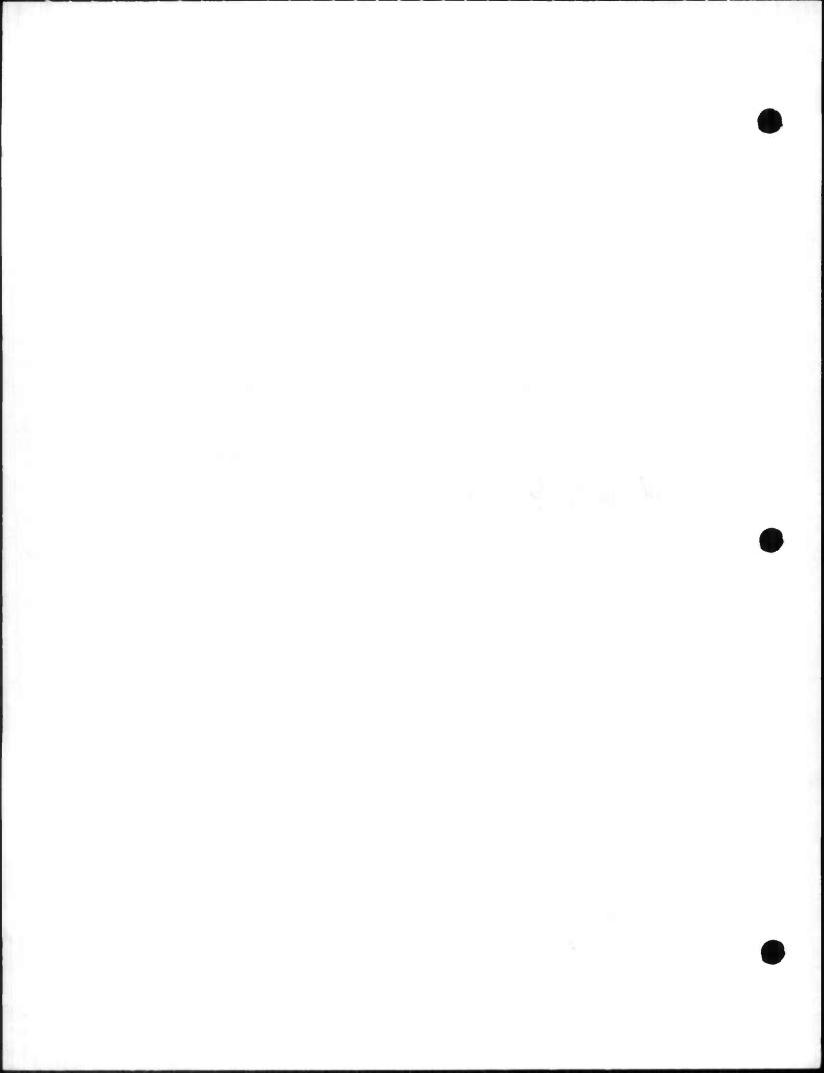
| | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First | Adiabata da ant | STATE OF I | | CERTIF | ICATE | OF | DEA | TH | | REG. NO | | | |
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| | NEVA L | | HEUS | | | | | | | 2. DAT | Ig 20, | 7995 | YEAR | 3. TIME OF OEATN 12:36PM |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yr | s. last birthday) | IF UNDER | YEAR | IF UNDE | R 24 HRS. | _ | E OF BIRTH | 2777 | | HPLACE (State or Foreign |
| | 214-07-34 | 478 | 1 - M 2 XF | | 83 YRS. | MONTHS | DAYS | HOURS | MIN. | Aug | ^{m, 2} 6 19 | 11 | Count | land |
| _ | 9e. FACILITY NAME (If not in | | | | | 9b. CITY, | TOWN C | OR LOCAT | ION OF D | EATH | | 9c. COL | INTY OF D | |
| DIRECTOR | Residence | | 1 Box 14 | + | | | Bar | ton | | | | A | 11ega | any |
| JEC. | 10a. STATE | 10b. COUNTY | r | | 10c. CIT | Y, TOWN OF | R LOCAT | ION | | | | | | 10d. INSIDE CITY |
| 2 | Fiaryland | | egany | _ | | Barto | n | | | | | | | LIMITS? |
| FUNERAL | Rt. 1 Box | | | | | | 101 | ZIP COO | | | | | | WHAT COUNTRY? |
| JNE | 11. MARITAL STATUS | . 14 | 12. WAS DECEDEN | IT EVED IN 11 C | ARMED | 1 42 W | 20050 | | 521 | | | | | States |
| | 1 Never Married 2 | | FORCES? 1 | YES 2 | ANO | 13. W | yes, sp | ecity Cubi | in, Mexica | nn, Puerto | IN? (Specify Yes Ricen, etc.) | or No- | Blac | E — American Indian, k, Whita, atc. |
|) BY | 3 Widowed 4 Divo | rced | | | | | | 2 (2)(10 | Specif | y. | | | Spec | White |
| TEI | (Specify onl | y highest grade | completed) | | (Give kind of life. Do NOT u | Work done do | CUPATIO | ON st of world | ng | 16 | b. KIND OF BUS | INESS/IN | DUSTRY | |
| PLE | Elementary/Secondary (6 Unknown |)-12) | College (1-4 or 5 | | Celanes | | | | | C | ellulos | e Ma | mufa | cture |
| COMPLETED | 17. FATNER'S NAME (First, M | liddle, Last) | | | - CIUITE | , Dini | ,10) | | NER'S NA | | Middle, Maiden | | illura | icture |
| BE C | Perry Llew | | | | | | | Lı | icret | tia S | Symons | | | |
| 0 | 19e, INFORMANT'S NAME (7 | ,, | | | | | | | | | nber, City or Town | | | |
| | Robert Ber | | | 1 | | | _ | | Plac | - | Jessup, | | | |
| | 20a, METHOD OF DISPOSITI | n 3 🗆 Rem | oval from State | cemeters | CE AND OATE | ther place) | | | 0.0 | DA | | | City or To | |
| | 21. SIGNATURE OF FUNERA | _ | ENSEE | | urel H | | | ID ADDRE | | | Da | LUII | , Md | • |
| | 17// | nen | 11/8 | nel | | B. | oal, | Func | eral | Hom | e . | | . 36 | , |
| | 23. PART t. Enter the di | Isomes, or o | omplications the | t caused the | death. Do | not anter t | ha mo | da of dy | ing, suc | h aa cai | Western | 1poe1 | rest. | Approximate |
| | ahock, or he iMMEDIATE CAUSE (Fin | eart fellure. | List only one cau | ise on eech | ilne. | | | | | | · | | , | Interval Between |
| | disease or condition | | | | | | | | | | | | | Onset and Death |
| - 1 | resulting in death) | → | Arterio | | | | dis | ease | | | | | | Uk yrs |
| | reautting in death) | → : | Arterio Diabete | | | | dis | ease | | | | | | |
| NOI | Sequentially list conditi | iona, | Diabete | (OR AS A COL | | F): | dis | ease | | | | | | Uk yrs |
| CATION | Sequentially list conditi if any, leading to immediate. Enter UNDERLYI | iona, diate | Diabete | (OR AS A COL | NSEOUENCE O | F): | dis | ease | | | | | | Uk yrs |
| TIFICATION | Sequentially list condition in any, leading to immediate. Enter UNDERLY CAUSE (Disease or injuithat initiated events | dona, dlate NG | Diabete Diabete | (OR AS A COL | NSEOUENCE O | F): | dis | ease | | | | | | Uk yrs |
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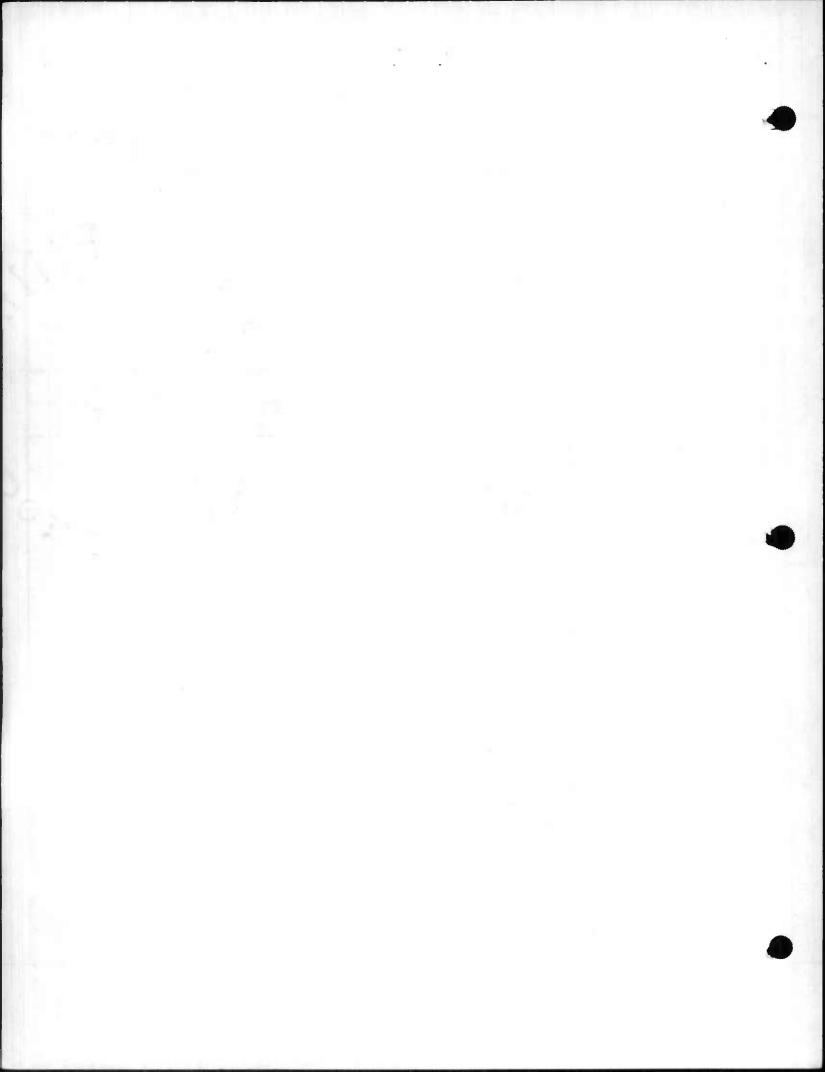
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the burial-transit permit. Pages 1, 2, 3 should be delached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE

| | REGISTRAR | | CERTIFICA | TE OF D | EATH | REG. NO | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DE | ATH |
| | JOHN JOSE | PH | MCCANN | | | AUGUST 17 | 1995 | 0420 | AM |
| | 4. SOCIAL SECURITY NUMBER 7 0 5 - 1 2 - 5 9 2 4 | | | | F UNDER 24 HRS. OURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 19 | 8. BIRT Coun | HPLACE (State or | |
| OR | 90. FACILITY NAME (If not institution, give str SACRED HEART HO | | | CUMBER | LOCATION OF DE | ATH | BC. COUNTY OF I | DEATH | |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 100. COUNTY MARYLAND ALL | EGANY | | IN OR LOCATION | | | | 10d. INSIDE C | ITY |
| | 100. STREET AND NUMBER | EGANT | COM | | | | | 1 (X YES 2 | |
| FUNERAL | 804 WASHINGTON | | | 2 | 1502 | | U.S. | | 7 |
| B | 11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 🔀 YES IF YES, GIVE WAR OR D. W. W. I I | 2 NO | If yes, specit | DENT OF HISPAN X Cultan, Mexical A NO Specify | IIC ORIGIN? (Specify Year, Puerto Rican, etc.) | Blec | E — American Ir ik, White, etc. | |
| 8 | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION | 16e. DECEDENT'S USUA (Give kind of work do | L OCCUPATION | f working | 16b. KIND OF BU | SINESS/INDUSTRY | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | SELF-EMPL | id.) | | R PAIN | TING | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) JOHN HENRY MCCA | NN | | | | ME (First, Middle, Maiden BRENNAN | Surneme) | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) ADELAIDE T. MCC | ANN | 196. MAILING ADDR | SHINGT | Number or Rurel R | oute Number, City or Tow | n, State, Zip Code) | 21502 | |
| | 20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Remote 4 Donation 5 Other (Specify) | val from State can | PLACE AND DATE OF DIS petery, crematory or other ple PFTFR & | ca) | | V /- | CATION — City of TO | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | IACHUACH. | | 32. NAME AND A | - UPCHU | | RAL HON | 1E, P. | A . |
| | 23. PART I. Enter the diseases, or co | implications that couse | the daeth. Do not en | ter the mode | of dying, such | as cerdiac or reap | ratory arrest. | Approxi | |
| | ahock, or heart fallure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) | let only one cause on e | Atahe | | | | ,, | Onset s | Between nd Death |
| z | | DUE TO (OR AS A | CONSEQUENCE OF): | 1.7 | | | | 154 | any |
| CATIO | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | 1,3 | and . |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| DICAL C | PART II. Other significant conditions Outgoing | contributing to deeth b | ut not resulting in the | underlying co | ousa given in i | Part I. 24s. WAS AN PERFOR | | WERE AUTOPSY AVAILABLE PRIC COMPLETION OF | R TO |
| Z I | | IDUTE TO CALICE O | F DE ATIL MES E | | | 1 🗇 YES 2 | NO | OF DEATH? | |
| PHYSICIAN: | DID TOBACCO USE CONTRI | | 26. PLACE OF DEATH (Che | | UNCERTAIN | | | | |
| Sic | | HOSPITAL: 1₩ Inpatient 2 □ ER/Outp | etient 3 DOA 4 I | | ☐ Residence | B ☐ Other (Specify) | | | |
| 到 | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Dey, Year) | 28b. TIME OF | 28c. INJURY WORK? | AT | 28d. DESCRIBE HOW II | NJURY OCCURED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | M | 1 TYES | 2 🗌 NO | | | | |
| | 3 Suicide 6 Could not be datermined | 26e. PLACE OF INJURY building, etc. (Spec | — Al home, farm, atreet, | actory, office | | 261. LOCATION (Street a City or Town, State) | ind Number or Rural I | Poute Number, | |
| COMPLETED | | AN: To the best of my know | | | | | |) and manner ee | stated. |
| S E | 29b. SIGNATURE AND TITLE OF CERTIFIER | 7. 417 | | | c. LICENSE NUM | | 29d. DATE SIGNED | 1 1/4 | 1117-711 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALISE OF DE | ATH (ITEM 27) (Sono Del-e) | | N1253 | 2 | AUGUST | 17 | 1995 |
| | George Breea 31. DATE FILED (Month, Day, Year) | M.D 9125 | eton Driv | e Cum | herlan | d MD | 21502. | , | |
| | 31. DATE PILED (Month, Day, Year) | Jahr Studion | Rardall | | | | | | |



| BALTIMORE, MARYLAND | cours after death. Page 6 may be retained by the hosp | filled in by the funeral director, page 5 should be detached on, or removal. | he medical examiner must be notified at once. |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Jours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Neath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR | | STATE OF I | MADVI AND | / DEDAG | TMENT | OF L | EAITU | AND I | MENTA | LUMEN | ır | | L1900 |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------|-----------------------------------|------------------------------------|---------------|---------------------|-------------|-----------|-------------|-------------------------------------|------------|-------------|-----------------------------------------------------|
| | 1 - STATE REGISTRAR | | SIAIL OF I | | CERTIF | | | | | MENIA | REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Lewellyn | Middle, Lest) | s, | Mill | | | | | | MONT | | AY | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUME | ER | 5. SEX | 6. AGE (In yrs. | | IF UNDER | 1 YEAR | IF UNDER | | | of BURTH | 5,19 | | CLACE (State or Foreign |
| | 227-09-19 | 95 | 1 🗆 M 2 🖾 F | | 3 YRS. | MONTHS | DAYS | HOURS | MIN. | (Mont 08 | /16/1 | | Vi | rginia |
| œ | 9a. FACILITY NAME (I not in Hartley Ha | | reet and number) | | | | | R LOCATIO | | | | | NTY OF DE | |
| DIRECTOR | RESIDENCE OF DEC | | | | | Poc | OIIIO | ke C | тсу | | | Wor | ces | ter |
| JEC | 10a. STATE | 10b. COUNTY | | | 10c, CfT | Y, TOWN O | R LOCAT | ION | | | | | | 10d. INSIDE CITY |
| | Virginia | Acc | omack | | Nev | v Ch | urc | h_ | | | | | | 1 X YES 2 NQ |
| FUNERAL | 10s. STREET AND NUMBER | | | | | | | . ZIP CODE | | | | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| NE | | | | | | | | 2185 | _ | | | | .A. | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 | Married | | YES 2 | NO | 1 | f yes, sp | ecity-Cuba | n, Mexica | n, Puerto | f? (Specify Yes Rican, etc.) | or No- | Black, | - American Indian, White, atc. |
| B | 3 Widowed 4 Divo | rced | IF YES, GIVE V | AR OR DATES | | ' | T YES | 2 1 NO | Specify | r: | | | Spec//) | nite |
| ED | 15. DEC | EDENT'S EDUC | CATION | 16a. | DECEDENT'S | USUAL OC | CUPATIO | ON . | | 16b | . KIND OF SU | SINESS/INC | | 1166 |
| COMPLETED | Elementary/Secondary (0 | | College (1-4 or 5 | +) | (Give kind of a life. Do NOT us | ne retired.) | suring mo | SI OF WORUN | g | | | | | |
| MP | 11 | | | H | ousew | ife | | | | | N/ | A | | |
| | 17. FATHER'S NAME (First, M | | | | | | | | | | Middle, Maiden | | | |
| BE | Anthony S | | 3W | - 1 | 105 MAN INC | ADDRESS | (Dam et a | | | | e Mar | | | |
| 2 | Richard N | | | | 190. WAILING | ADDRESS | (Street a | na Number | | | ber, City or Tow | | | 1D 21051 |
| | 20a. METHOD OF DISPOSITI | ON | | 20b. PLAC | CEANDDATE | OF DISPOS | ITION (Na | me of | | 200 | - 100-10 | CATION | Oh. or Tou | AD 21851 |
| | f E Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other | | oval from State | - Fir | st Ba | ther plece) | st (| Ceme | ter | v 8 | /28 P | OCOI | oka | City MD |
| | 21. SIGNATURE OF FUNERAL | L SERVICE LIC | ENSEE | | | 22. 1 | NAME AN | D ADDRES | S OF FAC | CILITY | Fox F | uner | al I | lome |
| | 1 am | n | . For | | | PO | Bo | x 27 | 8, | Tem | oeran | cevi | lle | VA 23442 |
| CATION | iMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to immediates. Enter UNDERLY! CAUSE (Disease or inju | ona, MG | DUE TO | ISE ON EECH II | lera SEQUENCE OF SEQUENCE OF | lie Ay | | | | | | ratory arr | eat, | Approximate interval Between Onset and Death 2 Yrs |
| ERTIF | that initiated events resulting in death) LAS | · (. | l | (OR AS A CONS | SEGUENCE OF | r): | | | | | | | | |
| MEDICAL C | PART II. Other aignificant fusuling CVA us Gastroe | Dej cifli sopli | contributing to numbers Right | deeth but no Did Hen Ref | Bete | | nel | elite e | res | | 24e. WAS AN PERFOR 1 YES 2 | MED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER | | ACE OF OR | ATH (Che | ick only on | (0) | | | |
| PHYS | 1 YES 2 PR NO | | 1 Inpatient 2 A | | 3 DOA | - | ing Hom 28c. INJ | 5 Re | Idence | - | | WILLIAM OO | NIDER. | |
| - 4 | 1 Natural 5 🔲 | Pending | (Month, D | ay, Year) | | URY | WO | RK7 | NO | 200. DES | CRIBE HOW I | NJUNY OCC | UNED | |
| IEU BY | 3 Suicide 6 | nvestigation Could not be letermined | 28e. PLACE Q building, | F INJURY At atc. (Specify) | home, farm, | street, facto | | | | | ATION (Street is or Town, State) | and Number | or Rural Ro | ute Number, |
| 9 | 29a. CERTIFIER | EVINO BUVBIO | MAN To the house | | | | | | | | | _ | | |
| COMPLE | | | ZIAN: To the best of R: On the beels of e | | | | | | | | | | | and manner ea stated, |
| | 295. SIGNATURE AND TITLE | OF CERTIFIER | | | 1 - | | | 29c. LICE | NSE NUM | SER | | 29d. DATI | E SIGNED (| Month, Day, Year) |
| | Riegori | 1001 | 'sel | ord | mil | ?, | | D | 295 | 505 | | 8 | -2. | 5-95 |
| 2 | GREGORIO | | | | | | FF | HW | 2002 | D/ A | PICE | (EL F | 141 | 0101- |
| - 100 | 0 | / | | 01.11 | 1.71 | 4/0 | har har t | 7,-00 | 100 | 41/6 | NIVI I | CLL | MI | 21817 |



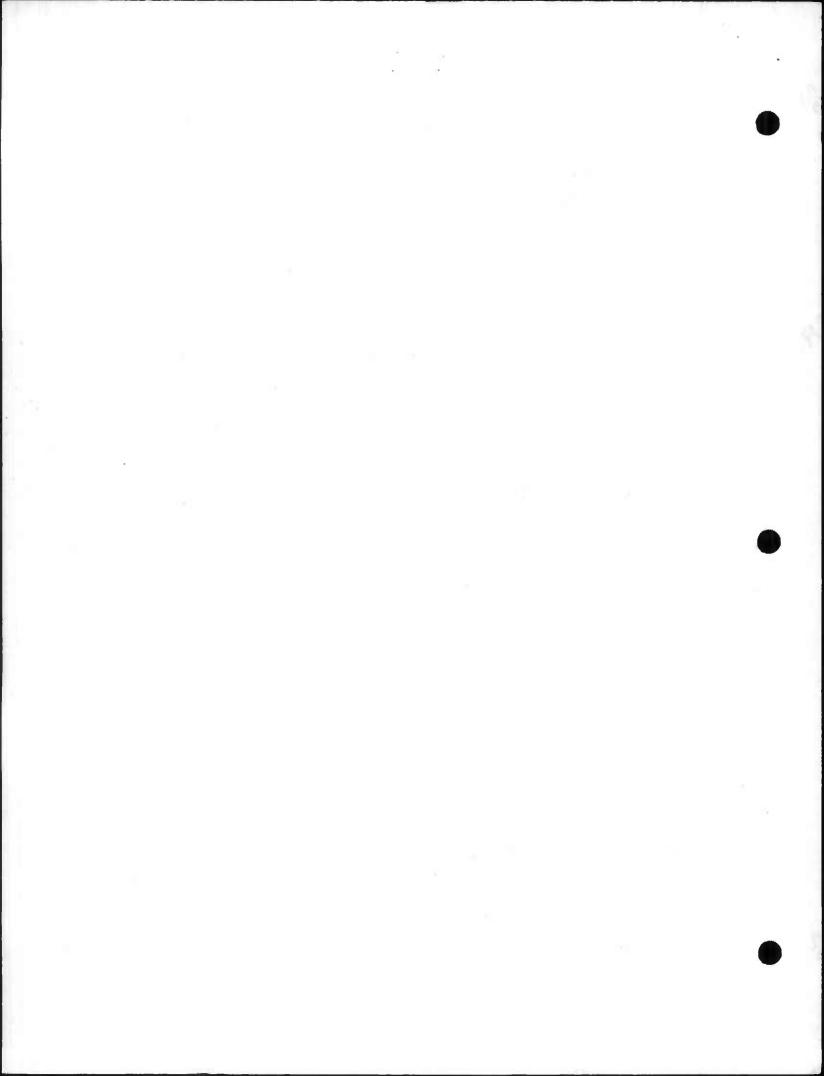
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an event leads. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI CERTIFIC | | | MENTAL HYGIEN | | | |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------|--------------------|-------------------------------------------------------------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MARIA AS | scension | MELEND | EZ | | 2. DATE OF DEATH OF AUGUST 2 | ĝ 199 ⁵ | 3. TIME OF DEATH 7:00 A M | |
| | 4. SOCIAL SECURITY NUMBER 212-40-6919 98. FACILITY NAME (If not institution, give size | 1 M 2 X F | 94 YRS. | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIFTH (Month, Day, Year) 9/7/1900 | | BIRTNPLACE (State or Foreign Country) Mexico | |
| TOR | Berlin Nursing | | | Berli | R LOCATION OF DE | EATN | 9c. COUNTY | of DEATH Cester | |
| DIRECTOR | 10e. STATE 10b. COUNTY | rcester | | Ocean (| 71. | | | 10d. INSIDE CITY LIMITS? 1 YES 2X NO | |
| FUNERAL | 10. STREET AND NUMBER 14107 Fiesta | RD | | | ZIP CODE | | | OF WHAT COUNTRY? | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES | 2 X NO | If yes, spe | 21842 ENDENT OF HISPAN city Cuban, Maxica 2 \(\bar{\pi}\) NO Specify XICan | IIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | or No- 14. | RACE — American Indian, Black, White, etc. Specify: In EXICAN White | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | life. Do NOT use n | BUAL OCCUPATION k done during most retired.) | N | 16b. KIND OF BU | | | |
| MP. | UNKNOWN 17. FATNER'S NAME (First, Middle, Last) | | House | wife | | Hoi | | | |
| | Francis DeAsto | raa | | | | ME (First, Middle, Meiden | PILOF | N | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | ı qu | 19b, MAILING AL | DDRESS (Street en | | sion (-unk | | de) | |
| 6 | Lita Marie Hamil | l | 14107 | Fiesta | RD Oce | an City. N | AD 21 | 842 | |
| | 20e. METHOD OF DISPOSITION 1 | oval from State | PLACEANDDATEGE | pisposition (Nar open Cr | ematory | 8/28/95 F | CATION CIN | es Teure State | |
| | 21. SIGNATURE OF FUMERAL SURVICE LICE | Butas | | 108 | Williams | Burl St. Berli | bage F | uneral Home | |
| | 23. PART I. Enter the discess, or conchence, or heart fellure. L | ompilestions that coused let only one opuse on e | d the deeth. Do not ech line. | enter the mod | le of dying, suci | h ss cardiac or reap | Iratory arrest | Approximate Interval Between | |
| | iMMEDIATE CAUSE (Finel disease or condition resulting in death) | DUE TO (OR AS A | LENOTIC | - CAR | PIOVA | SCUCAR | Dre | Onset and Death | |
| NO | Sequentially list conditions, | SEIZUR | CONSEQUENCE OF): A CONSEQUENCE OF): | XDEN_ | _ | | | | |
| CERTIFICATION | If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | CONSEQUENCE OF): | | | | | | |
| CERTI | resulting in death) LAST | 1 | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions | contributing to death b | out not resulting in | the underlying | ceuse given in | Part i. 24s. WAS AN PERFOI | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO | |
| ä | | | | | | | | | |
| ic i | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | q | THER: | ACE OF DEATH (Che | | | | |
| H XS | 1 VES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outp | 28b. TIME C | | | 6 ☐ Other (Specify) 28d. DE\$CRIBE NOW | N HIEV OCCUP | ED. | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJUR | | RK? | and Describe NOW | NOONT OCCOM | | |
| тер ву | 2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | |
| COMPLETED | | CIAN: To the best of my know | | | | | | use(s) and manner se stated, | |
| BE | 296. BIGHATURE AND TITLE OF BERTIFIER | ier, | - CV | \ | 29c. LICENSE HUN D46257 | | 294. DATE SH | 28/95 Maring Comp. Major | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO EDWIN CASTANEDA | | | ANKLIN | AVE. B | ERLIN MD | 21811 | | |
| 7 | AUG 28 199 | 5 Juli Sen | ATURE | | | | | | |



3. TIME OF DEATH

10d. INSIDE CITY

14. RACE - American Indian, Black, White, etc.

Specify: WHITE

1 YES 2 NO

Interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS

1 YES 2 NO

29d, DATE SIGNED (Month, Day, Year)

AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

0015

S. BIRTHPLACE (State or Foreign

VA.

10g. CITIZEN OF WHAT COUNTRY? USA

9c. COUNTY OF DEATH

WORCESTER

2. DATE OF DEATH

AUGUST 17, 1995 YEAR **IRENE** McELREAVEY G. A SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 175-28-2983 95 HOURS 1-18-00 1 - M 2 - TE VDS Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH ATLANTIC GENERAL HOSPITAL BERLIN DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION BERL IN Mp. WORCESTER permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 21811 241 WINDJAMMER RD. be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) JAMES W. LESTER SARAH COOPER BE notified funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code
928 OCEAN PINES BERLIN, MD., 21811 2 IRENE A. MCELREAVEY 928 OCEAN PINES hours after death. Page 6 may be Pe 20a. METHOD OF DISPOSITION
1 □ Burlel 2/3 Cremation 3 □ Ramoval from Stale
4 □ Donation 6 □ Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 8-18 SALISBURY, MD. SALISBURY CREMATORY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD. completely filled in by the rial, cremation, or removal. medicai 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart fallure. List only one cause on each line IMMEDIATE CAUSE (Final the disease pr condition Due to (or as a consequence of): resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 that the death certificate be executed wit an and com to burial, sementia CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) attending physician a ental Hygiene prior to numonia CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST 10 the atter Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? by and shows any Anemia signed l 1 TYES 2 NO HM been t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗵 UNCERTAIN 🗆 PHYSICIAN: has be Dept. DR ATTENDING PHYSICIAN: The law 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Rem certificate I HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Reeldence 6 Other (Specify) 6 中 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this with 1 Natural 1 YES 2 NO ВУ After 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Soecify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 G 6 Could not be DIRECTOR: J 4 Homicide 28 datarmined ם 29a. CERTIFIER

There and 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner se stated. COMPL TO THE HOSPITAL D TO THE FUNERAL DI DE filed within 72 ho IMPORTANT: If Ite 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 1000 H44828 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Brookeller

Bruley

32. BEOISTRAR'S SIGNATURE

This Dender Rudall

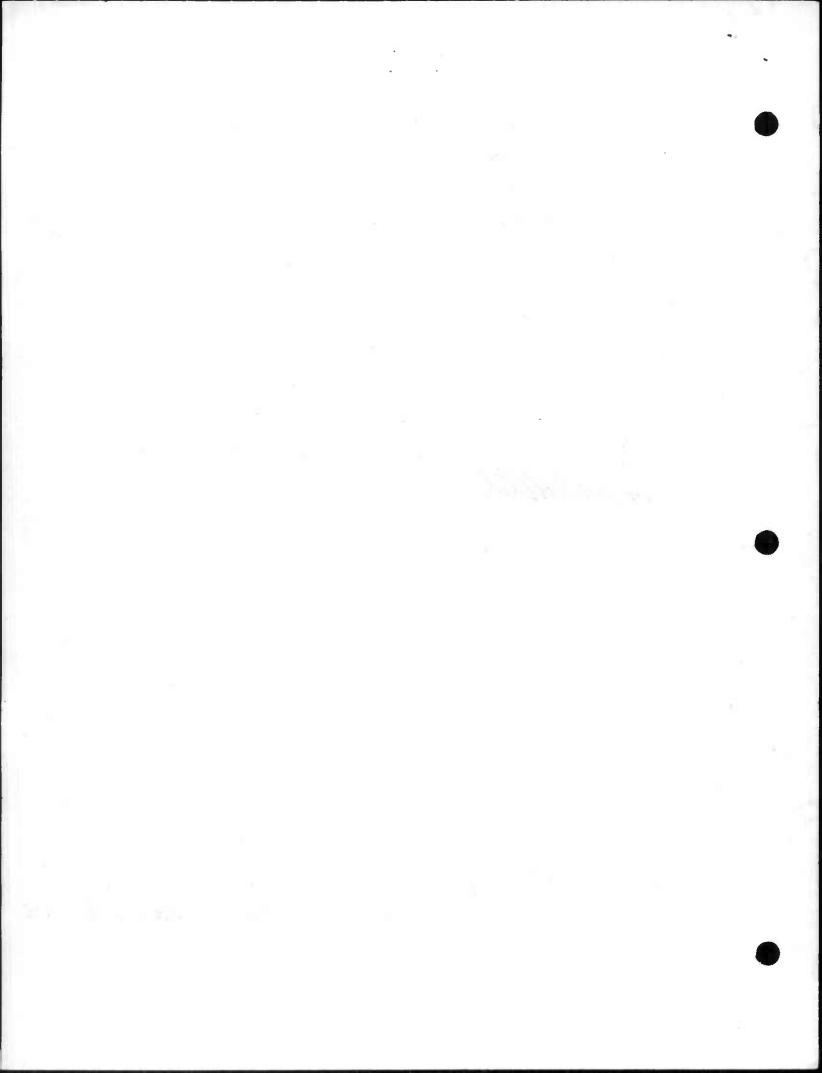
AUG 24 1995

1001

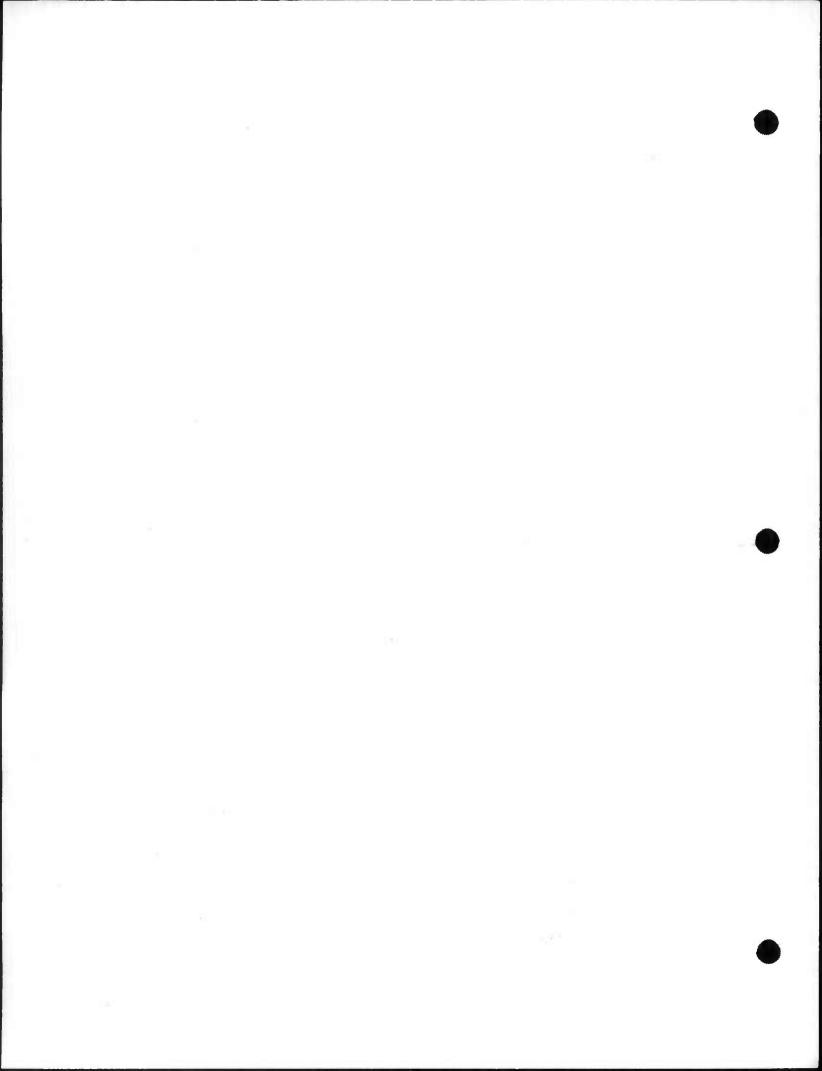
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last,



| | | 1 - STATE REGISTRAR | TE OF MARYLA | ND / DEPAR CERTIF | RTMENT OF I | HEALTH AND | MENTAL | HYGIEN REG. NO. | | | |
|-------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------|--------------------------------------------------|---------------------------------------------------------|---------------|--------------------|-----------------|--------------------|--------------------------------------------------------|
| | | t. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE (| OF DEATH | NY Y | EAR 3 | . TIME OF DEATH |
| | | LILA 4. SOCIAL SECURITY NUMBER 5. SEX | 8 ACE (1) | MOWB: | T | | AUGU | JST 2 | 4 19 | 95 | 13:40 ** |
| | | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | 2 F 77 | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | Day, Year) | | Country) | ACE (State or Foreign |
| 3 should | | 9e. FACILITY NAME (If not institution, give etreet and n | | . 30 | 9b. CITY, TOWN | OR LOCATION OF D | UUDE EATH | 16,19 | 9c. COUNTY | OF OEA | 44.434 |
| 1, 2, | СТОВ | MEMORIAL HOSP. & | | CTR. | CUMBE | RLAND | | | ALLE | GAN | Y |
| permit. Pages | DIRE | Marryland Marrylany | | | y, town on Local aconing | TION | | | | 122 | Dd. INSIDE CITY LIMITS? TYPES 2 NO |
| 155 | FUNERAL | 47 Jackson Street | | | | 539 | | | USA | | AT COUNTRY? |
| 215-0020 attending physician. se as the burial-transit | BY | 1 Never Merried 2 - Merried FOR | OECEDENT EVER IN ICES? 1 YES ES, GIVE WAR OR DAT | 2 -NO | If yee, sp | ENDENT OF HISPAI ecity Cuben, Mexico 2 NO Specifi | en, Puerto Ri | | | RACE — Black, V | American Indian, White, etc. |
| for the | PLETED | | (1-4 or 5 +) | | USUAL OCCUPATION Work done during most retired.) | | 166. | Home | INESS/INDUS | TRY | |
| 5 2 T | E COMPL | 17. FATHER'S NAME (First, Middle, Last) John R. Merrbaugh Sr | • | | | 18. MOTHER'S NA Barbar | | | | | |
| oe retained le 5 should re 5 should | TO B | 190. INFORMANT'S NAME (Type/Print) Aaron Mowbray | | | | . ,Lonaco | Route Numbe | r, City or Town | , State, Zip Co | de) | |
| ath. Page 6 may be meral director, page 9 | | 20e. METHOD OF DISPOSITION 1 Strict Suriel 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) | State 20b.1 | PLACE AND DATE | of disposition (Na Transpired) | ery Aug | .27,1 | 20c. LOC 995 M | CATION — City | or Town | state. |
| ex le de A | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | Eichh | orn-McKe | nzie | Funera | al Hom | e | |
| the the | | 23. PATT Enter the diseases, or compiles shock, or heart feliure. List only IMMEDIATE CAUSE (Final disease or condition resulting in death) | lmonary E | mbolism | not enter the mo | de of dying, suc | th sa cerdi | ec or respir | ratory srrest | • | Approximate interval Between Onast and Deeth 34 Days |
| precuted and com burial. | TION | Sequentially list conditions, if any, leading to immediate | ep Vein T | hrombop | hlebitis | , Left L | eg | | | | 34 Days |
| th certificat anding phy Hygiene p | ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | | |
| 0 E E E | O | | | | | | | | | | ERE AUTOPSY FINDINGS |
| signed by leatth any | MEDICAL | Chronic Renal Failure | | | | | | | | | ALABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 22 NO |
| - 0 0 0 d | | DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH. VES ET ALO ET ALLESTONAL ET | | | | | | | | | ☐ FES ZZE NO |
| E se E | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO TO NO | ITAL: | | TH (Check only one) OTHER: | | | | | | |
| SICIAN certific the S | PHYS | | otlent 2 ER/Outpe | 128b, TIM | | e 6 Reeldence | | | IJURY OCCUR | FO | |
| ATTENDING PHYSICIAN: ECTOR: After this certifica s after death with the St 28 is marked, or it | ВҰ | t Netural 5 Pending 2 Accident Investigation 3 Suitelds 269 | (Month, Day, Year) PLACE OF INJURY | ING | M 1 . | RK? YES 2 NO | | | | | |
| OR ATTEN DIRECTOR: nours after tem 28 is | ETED | the determined determined | | | | | | | | TOOK TENER | e Nation, |
| ₹ | COMPL | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To to | | | | | | | | Puse(s) er | nd manner ee stated. |
| TO THE HOSPI TO THE FUNEI TO FIED WITHIN | TO BE C | 29b. SIGNATURE IND TITIZE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (MC | | | | | | | | | 25 1995 |
| 4 | - | DR. ROBUSTIANO BAR | RERA, M | EMORIA | | TAL MEI | DICAI | BLD | GCT | MBF | RLAND, MD |
| / | | | HOGISTRAN'S SIGNAT | TURE Pardall | | | | | | | |
| | | MOG & 0 1333 | | | | | | | | | DHMH-16 Rev 1/8 |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

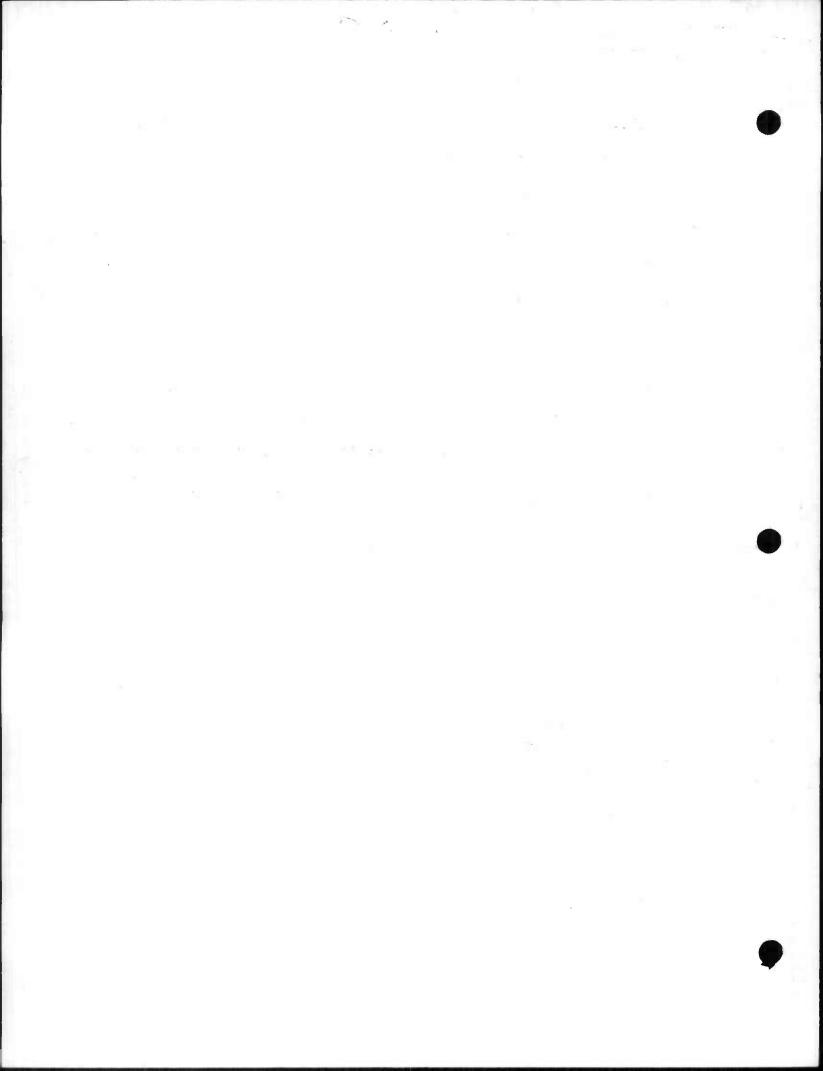
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If I lem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| 1 - | FOR STATE REGISTRA | F |
|------|--------------------------|---|
| 1. 0 | ECEDENT'S N | A |

| - | REGISTRAN | | | -11111 | ICAIL | OF DE | MILL | | REG. NO. | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------|----------------|-----------------|------------------------|-----------------------------|---------------------------------------|---------------------|--------------|----------------------|-------------------------------------|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | ' ' | | | | | 2. DATE OF MONTH | DEATH DA | W_ | YEAR 3. | TIME OF DEATN |
| | 4. SOCIAL SECURITY NUMBER | | ichae | | | | | | | 18 | 1495 | 3:50 PM m |
| | | 5. SEX 1 ☐ M 2 🔯 F | 6. AGE (In yrs. le | yrs. | MONTHS D | EAR IF L | INDER 24 HRS. | 7. DATE OF (Month, E | BIRTN Day, Year) | | 6. BIRTNPL Country) | ACE (State or Foreign |
| | 213-09-4937 9a. FACILITY NAME (If not institution, give si | | 83 | THS. | | | | April | 4, 1 | 912 | | |
| œ | | | | | | | CATION OF O | | | 9c. COUR | NTY OF DEAT | 'H |
| DIRECTOR | University Hosp | ital | | | Ba. | Ltimo | re Ci | ty | | | | |
| E | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR I | OCATION | | | | | 10 | d, INSIDE CITY |
| 5 | Maryland H | arford | | Ab | erdee | 1 | | | | | 11 | LIMITS? |
| | 10e. STREET AND NUMBER | | | 1 | | 10f. ZIP | CODE | | | 10g. CITI | | T COUNTRY? |
| FUNERAL | 125 Mt. Royal A | venue | | | | | 21001 | | | rı | .S.A. | |
| S | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. A | RMED | 13. WAS | DECENDE | NT OF HISPA | NIC ORIGIN? (| Specify Yes | | | American Indian, hita, etc. |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | YES 2 X | NO | | | Cuban, Mexico NO Special | n, Puerto Rici | en, etc.) | - 1 | Black, W Specify: | hita, etc. |
| | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | | 20 | | | | | Whi | te |
| COMPLETED | 15. OECEDENT'S EDUC (Specify only highest grade | | (1 | Give kind of v | USUAL OCCL | PATION og most of v | vorking | 16b, K | IND OF BUS | INESS/IND | USTRY | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5 + | -) | s. Do NOT us | | | | | | | | |
| M | 17. FATHER'S NAME (First, Middle, Lest) | 0 | | Home | maker | | | | In ho | | | |
| | Shirley Archer | Mitaball | | | | | | ME (First, Mid | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | MItchell | | | | | | an Nev | | | | |
| 2 | | | " | | | | | Route Number, | | | | 3 04 004 |
| | Mrs. Shirley La | ssen | 205 01 405 | | OF DISPOSITION | | | , ADE | - | | | d 21001 |
| 1 | 1 Burial 2 St Cremation 3 Remo | oval from Stata | compton or | amatan, as at | ther place i | | | 9/1 | | | City or Town, | |
| | 21. SIGNATUREJOF FUNERAL SERVICE LIC | ENSEE | I R. A | · rer | | | DRESS OF FA | | Iwest | . Cile | ster, | PA |
| | * Mary R. | Di Mi | ัดบันก | mi) | Tarı | ring- deen | Cargo , Mar | Funer | | me, | | - 1 |
| | 23. PART I. Enter the diseases, or o | omplications that | caused the d | eath. Do n | | | | | | | | Approximate |
| - 1 | shock, or heart failure. I IMMEDIATE CAUSE (Fine) | list only one ceu | se on each lin | е. | | | | | | | | Interval Batween Onset and Death |
| | disease or condition resulting in death) | DUE TO | ostino | Ho | tars | Fa | Jurg | | | | | |
| | resulting in descrip | DUE TO | OR AS A CONSE | OUENCE OF | 7): | 1 - 0 | 6 1100 | | | | | |
| z | Convenient that are dollars. |). | | | | | | | | | | |
| Ĕ | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSE | OUENCE OF | 7): | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Ë | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | | |
| 岗 | d | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FIN | | | | | | | | | | | |
| EDICAL | | | PERFORMED? AMAILABL COMPLET | | | | | MILABLE PRIOR TO MPLETION OF CAUSE | | | | |
| | 1 TYES 2 NO OF DI | | | | | | | | | | DEATH? | |
| 2 | DID TOBACCO USE CONTR | IBUTE TO CA | USE OF DEA | ATH YE | s \square NO | ПП | NCERTAI | νΠ | | | 1 '' | 1 165 2 110 |
| ₹ I | 25. WAS CASE REFERRED TO MEDICAL | | | | N (Check only | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpetlant : | B DOA | OTHER: | Home 5 | Residence | 6 Other (S | inec/fv) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF (Month, Da | INJURY | 28b. TIM6 | OF 28 | . INJURY A | | 26d. DESCR | | JURY OCC | URED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (International Control | y, reary | INJ | | WORK? | 2 NO | | | | | 9.73 |
| | 3 Suicide 8 Could not be | 26e. PLACE Of building. | FINJURY — At he | ome, ferm, s | treet, factory, | office | | 28f. LOCATIO | ON (Street a | nd Number | or Rural Route | Number, |
| COMPLETED | 4 Homicide determined | | | | | | | City Of 1 | own, State) | | | |
| 7 | 29a. CERTIFIER (Check only | IAN: To the best of | my knowledge, d | eath occurre | d at the fime, | date and p | lece, and due | to the cause(| a) and man | ner as state | d. | |
| ĕ I | one) 2 MEDICAL EXAMINER | | | | | | | | | | | d manner as stated. |
| O U | 296. SIGNATURE AND TITLE OF CENTRUES | 1 | Α. | | | 29c, | LICENSE NUI | /BER | | 29d, DATE | SIGNED (Ma | onth, Day, Year) |
| 0 | teter Ve | ince 1 | (D) | | | 1 | D 81 | dolo | | 1 de | f. | V2 1995 |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITE | M 27) (Type, | Print) | | | -0 - 1 | | 110 | - push | 401.113 |
| | teter Stem | RIS | | LLM | MS | 2. | 2 5 | 600 | NR < | H. | R'H' | he sin |
| ı | AUG 30 199 | 32. REDISTRAI | R'S SIGNATURE | _ | | | / | 04 | | | 701110 | 1011 |
| - 10 | 700 J U 199 | J Julia o | Davidson-1 | Carl-11 | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First | Middle, Last) | | | | | | | | 2. DATE OF DEATH | | T | 3. TIME OF DEATH |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------|---------------------------|-------------------------------------|-------------|--------------|-------------|-----------------------|-----------------------------------------|-----------------------------------|-------------|------------------|------------------------------------------|
| - 1 | JOSEPH | 1 | PAUL |] | NELS | ON | | | | AUGUST 20, | 199 | 5 YEAR | 2125 P M |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER | 1 YEAR | IF UNDER | | 7. DATE OF BIRTH | 177 | 8. BIRTHI | PLACE (State or Foreign |
| 1 | 215-26-7637 | | 1 M 2 - F | 64 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) AUG 26 19 | 30 | Country ?√i ∆ | RYLAND |
| | 9s. FACILITY NAME (If not in | stitution, give si | reet and number) | | | 96. CITY | , TOWN (| OR LOCATI | ON OF DE | | | INTY OF DE | |
| OR | SACRED HEA | | SPITAL | | | | CUMB | ERLAI | 4D | | ALI | LEGAN | Y |
| DIRECTOR | RESIDENCE OF DEC | 10b. COUNTY | , | | 40. 0. | | | | | | | | |
| E | W.VA. | | IERAL | | | Y, TOWN O | | NON | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | FILE | IEICAL | | | KIDGI | | | | | | | 1 YES 2 NO |
| RA | RFD#1 BOX# | 48 | | | | | 101 | 267 ^s | | | | | HAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 40 | 12 WAS DECEDEN | I EYER IN U.S. ARI | uen. | 10 | | | | HC ORIGIN? (Specify Yes | | S.A. | |
| | 1 Never Married 2 | | FORCES? 1 | YES 2 N | 0 | | if yes, sp | ecify Cuba | n, Mexice | n, Puerto Ricen, atc.) | or No- | Bleck, | - American Indian, White; etc. |
| BY | 3 Widowed 4 Divo | rced | IF TES, GIVE V | WIN ON DATES | | | I 🗌 YES | 2 NO | Specify | | | Specify | WHITE |
| COMPLETED | | EDENT'S EDUC | | 16a. DEG | CEDENT'S | USUAL O | CCUPATIO | ON . | | 18b, KIND OF BU | SINESS/INI | DUSTRY | |
| 9 1 | Elementary/Secondary (0 | | College (1-4 or 5 | +) | Do NOT us | se retired.) | | | _ | | an n | | |
| A P | 12 | | | CITY | OF | CUMI | BERL. | | | | CE D | EPT. | |
| 8 | 17. FATHER'S NAME (First, M | | | | | | | | | ME (First, Middle, Maiden | Surname) | | |
| 出 | PAUL NELS | | | | | | | | | KEECH | | | |
| 2 | PATRICIA DI | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | Number, City or Tow XINGTON, O | | 4490 | /1 |
| | | | | | | | | | | | | | |
| | 20s METHOD OF DISPOSIT 1 Burlel 2 Cremetto 4 Donation 5 Other | | oval from State | 20b. PLACEA cemetery, cren | natory or o | ther place) | | | | | | City or Tow | |
| 1 | 21. SIGNATURE OF FUNERA | | Eysyt | ROCKY | CAP | VET (| PAME AN | TERY D ADDRE | AUG SS OF FAC | 23 1995 R | FD_F | LINTS | TONE, MD. |
| 1 | | 41 | 11. 4 | | | | | | | FUNERAL H | | | |
| | 22 BART I Enter the d | 01/ | remu | | | 40 | 04 D | ECAT | UR S' | TREET CUMB | ERLA | ND MA | RYLAND |
| | 23. PART I. Enter the di ahock, or h | aart fallure. I | List only one cau | ise on aach iina. | eth. Do r | not anter | the mo | de of dy | ng, suci | h aa cardlac or reapi | ratory an | reat, | Approximate Interval Between |
| - 1 | IMMEDIATE CAUSE (Fir | iel. | P | | | 1 | | | | | | | Onset and Death |
| H | resulting in death) | → , | I. US | neum | na / | un | 2 | | | | | | lyear |
| _ | | | DUE 10 | (OR AS A CONSEO | UENCE O | F): | 1 | | | | | | 0 |
| CERTIFICATION | Sequentially list conditi | | DUE TO | (OR AS A CONSEO | UENCE OI | F): | | | | | | | |
| 8 | cause. Enter UNDERLY | NG | | | | | | | | | | | |
| Ĕ | CAUSE (Disease or injuthat initiated events | · • | DUE TO | (OR AS A CONSEO | UENCE OF | F): | | | | | | | |
| | resulting in death) LAS | ' La | i | | | | | | | | | | |
| 0 | PART II. Other significa | nt conditions | contributing to | death but not re | eulting | in the un | darlylno | Callea | alven in | Part I. 24s, WAS AN | ALITYADOV | 245 | WERE AUTOPSY FINDINGS |
| MEDICAL | Emphy | 24 | Deal | etra | | | aut y m | , cause § | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | PERFOR | MED? | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | | |) | | | | | | | 1 YES 2 | ONO | | OF DEATH? |
| 1 | DID TOBACCO U | SE CONTE | PIRLITE TO CA | LISE OF DEAT | TH YE | c NV i | JO [| LINC | ERTAIN | | | | 1 TES 2 NO |
| ¥. | 25. WAS CASE REFERRED TO | | IDOTE TO CA | | | TH (Check | | 1 0140 | EKIMI | 101 | | | |
| PHYSICIAN: | EXAMINER? | | HOSPITAL: | ER/Outpatient 3 | DOA | OTHER | | e 5 ∏ Re | eldence | 8 Other (Specify) | | | |
| Ě | 27. MANNER OF DEATH | | 28s. DATE OF (Month, D | INJURY | 28b. TIM | E OF | 28c. INJ | URY AT | | 28d. DESCRIBE HOW I | NJURY OC | CURED | |
| BY F | | Pending investigation | (moran, D | ay, rear) | INJ | M | | RK? 'ES 2 |] NO | | | | |
| 48 | 3 Suicide 6 | Could not be | 28s. PLACE O | F INJURY — At hon atc. (Specify) | ne, farm, s | street, fact | ory, office | | | 261, LOCATION (Street s | nd Number | or Rural Ro | oute Number, |
| E L | 4 Homicide | determined | | | | | | | | City or Town, State) | | | |
| 2 | 29e. CERTIFIER (Check only | IFYING PHYSIC | IAN: To the best of | my knowledge, des | th occurre | ed at the ti | me, data | and place, | end due | to the cause(s) end mer | ner se stat | ed. | |
| Solicition (Street and Number of Hursi House Number, City or Town, State) 29e. CERTIFIER (Check only onle) 2 MEDICAL EXAMINER: On the basis of sxamination end/or investigation, in my opinion, death occurred at the time, dets and place, and due to the cause(s) and manner as stated. | | | | | | | | and manner as stated. | | | | | |
| | | | | | | | | Month, Dev. Year) | | | | | |
| m Mo | | | | | | | 1/95 | | | | | | |
| 2 | 30. HAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUS | SE OF DEATH (ITEM | | | _ | 1 | () | | - 1 | 100 | 7. |
| | George. | Bre | 20 A | 1.D. 91. | 25 | etc. | 2D | riv | eU | imberlan | 1 1 | 1D 3 | 21502- |
| | 31. DATE FILED (Month, Day, | , | 32. DEGUÉTRA | A'S SIGNATURE | 0 11 | | | | | | | | |
| | Alicz | 2 1995 | Jana d | MUNICIPAL IN COM | ttall | | | | | | | | |
| | | | | | | | | | | | | | |

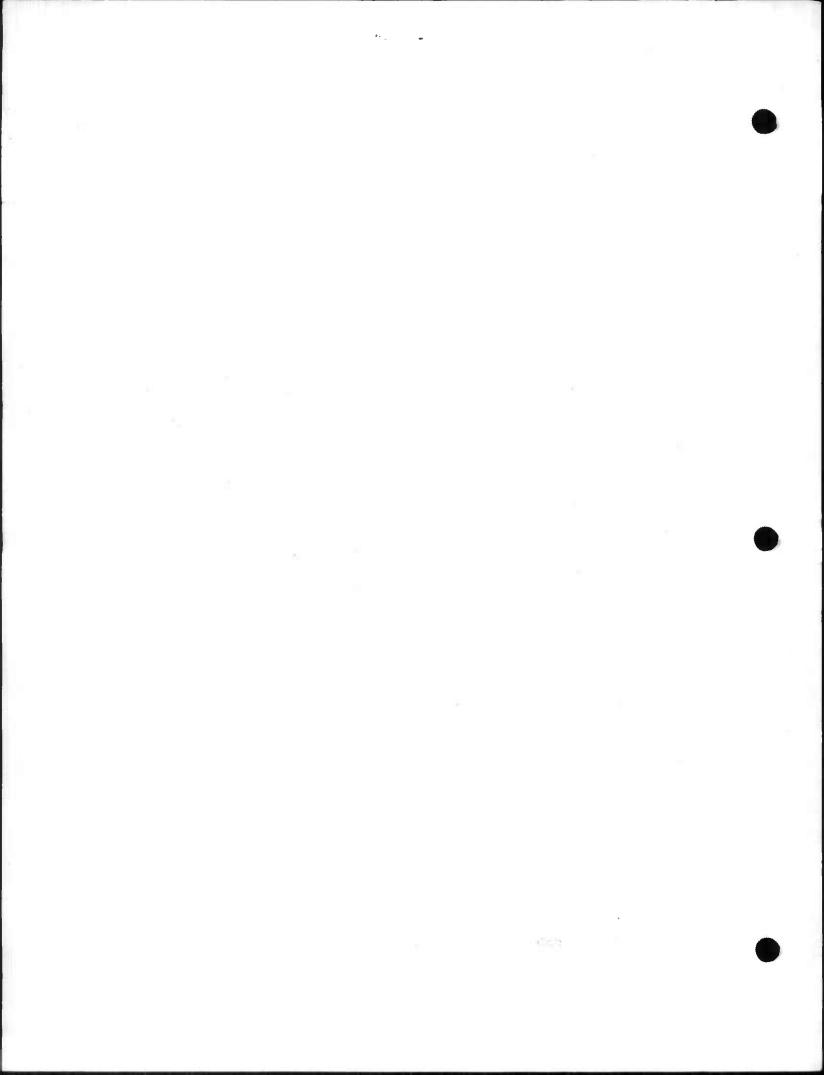
| BALTIMORE, MARYLAND 21215-0020 | burs after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | L OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral di hours after clearly with the State Derr of Health and Mental Horizon prior to build cremation, or removal | |

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| | | | | | | | | | | _ | HEG. NO. | | | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------|------------------|---------------------------------|-------------------------------------------------------|-------------|-------------|-----------------------|---------------|----------------------------------|-------------|-------------------|-------------------------------------------|
| | 1. DECEDENT'S NAME (First | | | | | | | | | MONTH | OF DEATH DA | W | YEAR | 3. TIME OF DEATH |
| | Charles | Howa | ird N | MAIR | | | | | | Augu | st 31 | , 199 | 95 | 6:30 p.m.m |
| | 4. SOCIAL SECURITY NUME | DER | 5. SEX | 6. AGE (in yrs. | last birthday) | | R 1 YEAR | | R 24 HRS. | 7. DATE C | F BIRTH Day, Year) | | 8. BIRTH Count | IPLACE (State or Foreign |
| - 3 | 213-10-539 | 7 | 1 🗓 M 2 🗌 F | 92 | YRS. | MONTHS | DAYS | HOURS | MIN. | | 12, 1 | 903 | | akland, MD |
| | 90. FACILITY NAME (If not in | stitution, give s | treet end number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA | | | | | | | | |
| E | 411 East P | onlar | St | | | | | Oak | land | | | C. | arret | |
| K | 411 East P | EDENT | DC. | | | | | Vak. | Lanu | | | Ge | arret | . L |
| DIRECTOR | 10a. STATE | 10b. COUNTY | , | | 10c. C/1 | Y, TOWN | OR LOCA | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| | MD | Ga | rrett | | | | | | 0al | kland | | | | 1 X YES 2 NO |
| AL | 10a. STREET AND NUMBER | 10f. ZIP CODE | | | | | | 10g. CIT | IZEN OF V | WHAT COUNTRY? | | | | |
| FUNERAL | 411 East Poplar St. | | | | 21550 | | | | | | , | JSA | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AI | | | | | 13. | WAS DEC | | | NIC ORIGIN? | (Specify Yee | | 14. RACE | - American Indian. |
| | 1 Never Married 2 X | | FORCES? | YES 2 | ∑ ио | | | | on, Mexice Specifi | n, Puarto Ri | cen, atc.) | | Speci | k, White, etc. |
| BY | 3 Widowed 4 Divo | rced | | | | | | Aug | opecn | y. | | | Speci | White |
| COMPLETED | | EDENT'S EDU | | 18e. 1 | DECEDENT'S | USUAL C | CCUPATION | ON | | 18b, | KIND OF BUS | INESS/IN | DUSTRY | |
| ы | Elementery/Secondary (I | | College (1-4 or 5 | +) | (Give kind of life. Do NOT u | work done se retired.) | during mo | st of worki | ng | | | | | |
| 릴 | 3rd | . | | | Ston | e Ma | son | | | | Mason | rv | | |
| 0 | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MOT | HER'S NA | | iddle, Meiden | | | |
| | William | Josh | ua N | lair | | | | M: | arv | E | 11en | | Smith | , |
| BE | 19e. INFORMANT'S NAME (| ype/Print) | | | 19b. MAILING | ADDRES | S (Street o | | - | | er, City or Town | | | |
| 5 | Elsie A. N | air | | | | | | | | | and, N | | | |
| | 20ar METHOD OF DISPOSIT | | | 20h PLAC | EANDDATE | | | | , | DATE | | | Cify or To | |
| | 1 Buriel 2 Cremetic | | oval from State | | crematory or c | ther place, | 1 | | | | | | | wii, State |
| - 1 | 21. SIGNATURE OF FUNERA | | ENSEF | | <u>Ua</u> | klan | | | TY SS OF FA | 9/3 | Dak | <u>Land</u> | , MD | |
| | NO 01 |) ~ | Th | 9 | | | | | | ral H | ome | | | |
| | Brad | ten H. | duelle. | 4 | | | 32 S | Sec | cond | St., | 0ak1a | and. | MD | 21550 |
| NO | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditione, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interval Batween Onset and Death disease or condition. Atherosclerotic cardiovascular disease 3 weeks DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | | |
| 2 | PART II. Other significe | nt condition | e contributing to | death but no | resulting | In the u | nderlyIn | cause | given in | Part I. | 24a. WAS AN | AUTOPSY | 24b | . WERE AUTOPSY FINDINGS |
| MEDICAL | Prostate | | | | _ | ming in the didditying dauge given in Part i | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 8 | Dysphazia- | | | 1000 | | | | | | | 1 YES 2 | X NO | | OF DEATH? |
| | Dysphazia | dicer | tain eti | JIOGY | | | | | | | | | | 1 TYES 2 NO |
| AN | 25. WAS CASE REFERRED TO | O MEDICAL | | | | | | | | | | | | |
| ^등 | EXAMINER? | O MEDICAL | HOSPITAL: | | | OTHE | R: | | | eck only one | | | | |
| PHYSICIAN: | 1 YES 2 NO | | 1 Inpatient 2 | | _ | | | | eeldence | 8 Other | | | | |
| | | Pending | (Month, E | | 28b. TIN | JURY | | RK? | - 22 | 28d. DE\$0 | PRIBE HOW IF | NJURY OC | CURED | |
| B | 2 Accident | Investigation | 20- 21-20- | E this is low. | | | | /ES 2 [| _) NO | | | | | |
| | 3 Suicide 8 Homicide | Could not be determined | building, | otc. (Specify) | nome, term, | street, fec | tory, offic | • | | | TION (Street e r Town, State) | nd Numbe | r or Rural F | Route Number, |
| COMPLETED | | | | | | | | | | | | | | |
| 립 | | IFYING PHYSI | CIAN: To the beet of | my knowledge, | death occurr | ed at the | time, date | end place | , end due | to the caus | e(e) end men | ner ee sta | ted. | |
| O | one) 2 MED | ICAL EXAMINE | R: On the basis of s | xamination end/o | or investigation | on, in my | opinion, d | eath occu | red at the | time, date o | and plece, en | d due to ti | he couse(e |) end manner ea stated. |
| | 296. SIGNATURE AND TITLE | OF CHRTIFIES | 01 | 1 ~ | | | | 29c. LIC | ENSE NUI | MBER | | 29d, DAT | E SIGNED | (Month, Day, Year) |
| 8 | LING | MK | Luni | 20 | | | | | D300 | | | • | | |
| 2 | 30. NAME AND ADDRESS OF | F PERSON WH | O COMPLETED CAU | SE OF DEATH (1) | EM 27) (7/m | , Print) | | | שטטנע | ,,, | | | 9/1/ | 7.7 |
| | | | | | | | 0- | 1-1 | | (n1 - | - d 0 | 1550 | | |
| | Dr. Donald 31. DATE FILED (Month, Quy, | Yeard | _ 32. REGISTRA | R'S SIGNATURE | DOX | 1473 | , Už | KLAT | ia, P | aryıa | and Z | 1000 | , | |
| | 31. DATE FILED (MOSIN, Day, | 1 199 | 5 Julia | AR'S SIGNATURE | Rardall | | | | | | | | | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If I lem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | | - | PERIIL | ICALE | OF DEAT | П | R | EG. NO. | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) H.E.L.E.N. | M - CATT | | M | EWTON | | | 2. DATE OF I | DA | Y | YEAR | 3. TIME OF DEATH |
| | | McCALL | | | EWION | | A | August | 29 | 1995 | 5 | 4:35 8 " |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER 1 YE | | | 7. DATE OF E (Month, De | WRTH Wast | | 8. BIRTI | NPLACE (State or Foreign |
| | 217-10-8428 | 1 M 2 X F | 84 | YRS. | -MONTHS DA | YS HOURS | MIN. | Feb. | | 911 | | land |
| | 9e. FACILITY NAME (If not institution, give a | street end number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE | | | | | | | |
| H | 108 West End A | ve. | | | (| Cambridg | ge | | | Dor | ches | ster |
| E | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 2 | 10a. STATE 10b. COUNT | 10c. CIT | Y, TOWN OR L | OCATION | | | | | | 10d, INSIDE CITY | | |
| ₫ | Maryland Doro | chester | | | Caml | oridge | | | | | | LIMITS? 1 XXYES 2 NO |
| A | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | | | \neg | 10g. CIT | IZEN OF Y | WHAT COUNTRY? |
| FUNERAL DIRECTOR | 108 West End Ave. | | | 21613 | | | | | | U. | S.A. | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. | ARMED | 13. WAS | DECENDENT OF | HISPANIC | ORIGIN? (Sc | nacify Yea | | | |
| Ū, | 1 Never Married 2 Merried | FORCES? 1 | | NO | It ye | s, specify Cuben, | Maxicen, I | | | 0. 110 | | E — Americen Indian, k, White, atc. |
| ВУ | 3 X Widowed 4 Divorced | 1 120, 0172 18 | AN ON DAILS | | '' | YES 2 X NO | ареспу: | | | | Spec | <i>™</i> white |
| COMPLETED | 15. DECEDENT'S EDU | CATION | 16a. | DECEDENT'S | USUAL OCCU | PATION | | 16b. KIN | D OF BUS | INESS/IN | DUSTRY | |
| Щ | (Specify only highest grade | College (1-4 or 5+) | | (Give kind of ville. Do NOT us | work done durin se retired.) | g most of working | | | | | | |
| ם | 8 | | | home | maker | | | | | | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTNE | R'S NAME | (First, Middle | e. Meiden S | Surname) | | |
| | Harry | C. McCa | a11 | | | | Ma | rv B | Barbe | r | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS (St | eet end Number o | _ | | | | n Codel | |
| 5 | Mrs. Doris N. Ins | sley | | | | d Ave., | | | | | | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLAC | | OF DISPOSITIO | | | DATE | | | City or To | State . |
| | 1 X X Burial 2 Cremetion 3 Rem 4 Donation 8 Other (Specify) | ovel from State | cemetery. | cremetory or o | ther placel | ial Par | ale C | 1 | | | • | ryland |
| | 21. SIGNATURE OF AUMERAL SERVICE LIC | CENSEE | IDOIC | lester | | E AND ADORESS | | | Callin | TUE | e na | ii y i and |
| | X. FI | R Mon | 0 | | | mas Fur | | | | | | |
| | 2 (7 1-100 - 27) | | | 77 | 700 | Locust | St. | Camb | ridg | e MI | 216 | 513 |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications thet | ceused tha | deeth. Do r | not enter the | mode of dylng | g, such a | na cerdiac | or reepir | atory ar | rest, | Approximata |
| | shock, or neert laliure. | | | | | | | | | | | |
| immediate cause (Final disease or condition resulting in death) a. Pronchesource Garcinoma of Lung Due to (Oras a consequence of): | | | | | | | | | | | | Onset and Death |
| | iMMEDIATE CAUSE (Final disease or condition | Brand | | | 9 | | 60 | 1 | | | | Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Bronce Due to | | | arcin | oma | 6C | lux | eg_ | | | |
| 7 | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Bronce Due to | | | arcin | ome | 6F | lux | eg_ | | | |
| NOI | disease or condition resulting in death) Sequentially list conditions, | b | | È C | | ome | 6£ | lun | y | | | |
| CATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING | b | ORAS A CONS | È C | | ome | 6F | lux | y | | | |
| IFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b DUE TO (| ORAS A CONS | BEOUENCE OF | F): | osma | 6 <u>C</u> | lun | eg_ | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | b DUE TO (| OR AS A CONS | BEOUENCE OF | F): | ome | 6F | lun | rg | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CONS | BEOUENCE OF | F): | | | | eg_ | | | |
| | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (| OR AS A CONS | BEOUENCE OF | r): r): in the under | lying cause giv | | | WAS AN / PERFORM | | 246 | Onset and Death |
| | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (| OR AS A CONS | BEOUENCE OF | r): r): in the under | lying cause giv | | irt I. 24a | . WAS AN A | HED? | 246 | Onset and Death 18 Weight Ker WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDICAL | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CONS | BEOUENCE OF | r): r): in the under | lying cause giv | | irt I. 24a | . WAS AN A | HED? | 24b. | Onset and Death 18 War Ker WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| MEDICAL | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (| OR AS A CONS | SEQUENCE OF | r): In the under | lying cause giv | | irt (. 24a | . WAS AN A | HED? | 246. | Onset and Death IS the on Ker WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition Live Live Live Condition DID TOBACCO USE CONTI | DUE TO (| OR AS A CONS OR AS A CONS death but no | BEOUENCE OF | r): In the under | iying cause giv | ven in Pa | irt (. 24a | . WAS AN A | HED? | 24b. | Onset and Death IS the on Ker WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Condition Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics and Chronics a | DUE TO (| OR AS A CONS OR AS A CONS Death but no | SEQUENCE OF TENNING SEQUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUENCE OF TENNING SECUEN | In the under | lying cause giv | ven in Pa | ort I. 24a | . WAS AN A PERFORM | HED? | 24b | Onset and Death IS the on Ker WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 | DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. DUE TO (c. 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DAT | CURED r or Rural F ted. ne cause(e | Onset and Daath IS the on Ker WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| leath. Page 6 may be retained by the hospital or attending physician. | funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | xaminer must be notified at once. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2% flours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

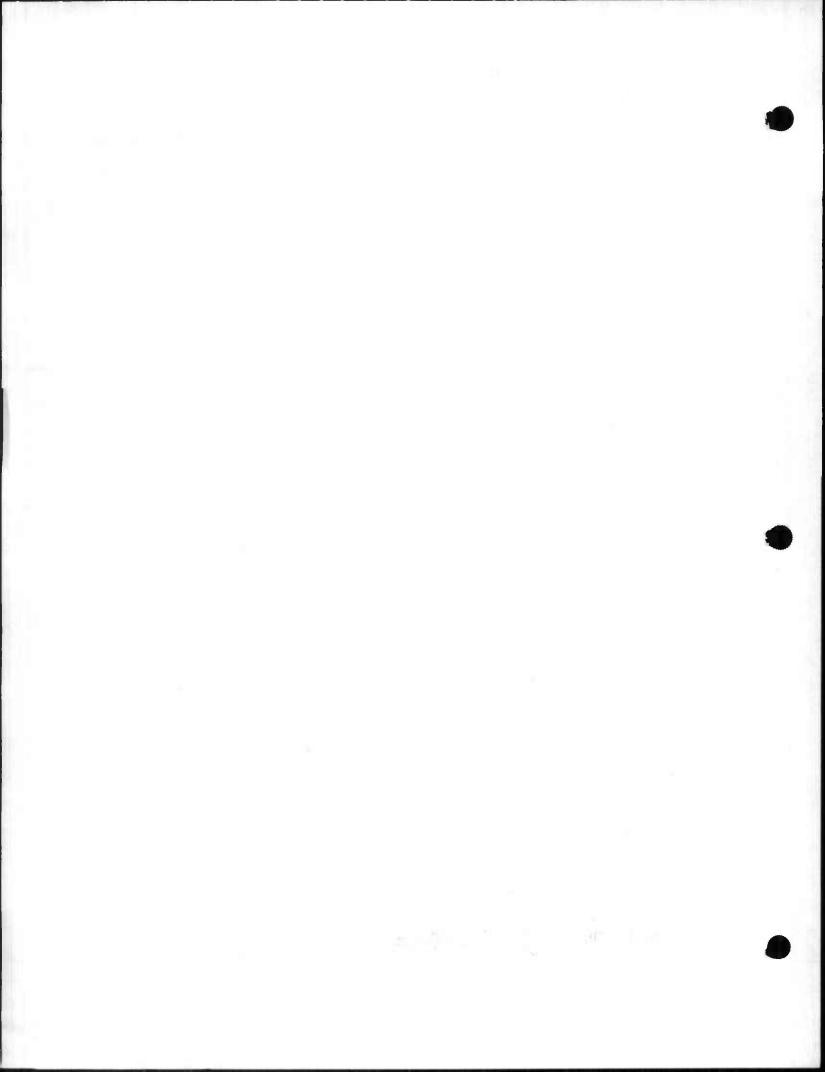
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|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------|------------------------|--------------|-------------|----------------|-------------|------------|------------------------------------|------------------|---------------|---------------------------------|
| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAR | RTMEN | IT OF H | IEALTH DEAT | AND 1 | MENTA | L HYGIEN | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | - | | | | | | | | OF DEATH | | 3. | TIME OF DEATH |
| | Esther | Bell (| Ott | | | | | | Aug | ust 13 | , 199 | YEAR 95 | 6:30 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | st birthday) | | ER I YEAR | IF UNDER | | 7. DATE | OF BIRTH | | 8. BIRTHPL | ACE (State or Foreign |
| | 222-18-1225 | 64 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Monti | 26, 1 | 021 | Country) | • | |
| | 9a. FACILITY NAME (If not institution, give a | treet and number) | | | 9b, CI1 | ry, TOWN (| OR LOCATIO | ON OF DE | EATH | 20, 1 | | TY OF DEAT | |
| 8 | 25607 Garey Road | | | | | Den | ton | | | | | roli | |
| DIRECTOR | 25607 Garey Road | | | _ | | | | | | | | | |
| 뿐 | 10s. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | TION | | | | | 10 | Id. INSIDE CITY |
| | Maryland Caro | line | | | Dent | ton | | | | | | 1 | YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | | 10g. CITIZ | EN OF WHA | AT COUNTRY? |
| | 25607 Garey Road | | | | | | 216 | 29 | | · · | U.S | 5.A. | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 2 Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | MED | 13 | I WAS DEC | ENDENT O | F HISPAN | VIC ORIGIN | 17 (Specify Yes Rican, etc.) | or No- | 14. RACE | American Indian, Thite, etc. |
| B | 3 Widowed 4 Divorced | IF YES, OIVE V | MAR OR DATES | | | 1 TYES | 2 X NO | Specify | y: | mount, stary | | Specify: | |
| ED | 15. DECEDENT'S EDUC | CATION | 140 00 | CEDENTIO | 1101141 | OCCUPATIO | | | 1000 | | 1 | | casian |
| | (Specify only highest grade | completed) | (G | Ive kind of the NOT us | work done | during mo | st of workin | ng | 18b. | KIND OF BUS | HNESS/INDI | JSTRY | |
| 12 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | na | How | ne/Foo | Ъс | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Leet) | | HOI | lemak | er/r | Food | | | | Middle, Meiden | | Ju . | |
| | | bie Mel | vin | | | | IS. MOT | | nnie | | | Hutse | on |
| BE | 19e. INFORMANT'S NAME (Type/Print) | DIE TREI | | h MAN INC | Anne | BB (Chart o | ad Mumbas | | | oer, City or Town | | | OII |
| 2 | Lowman L. Ott, J. | r. | "" | | | | | | | , Mary | | | 9 |
| | 200. METHOD OF DISPOSITION | 1. • | 20h BLACE | | | _ | | , De | | - | | | |
| | 20s. METHOD OF DISPOSITION 1 CKBuriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Denton Cemetery 8/16 Denton, Maryland | | | | | | | | | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LIC | ENSEE / | Dentor | 1 Cerr | | NAME AN | D ADDRES | SS OF FA | | o Dei | icon, | Mary. | Land |
| | 61-01 | 218-1 | Mark | | | | | | | me, P. | A. | | |
| _ | · Naucon | 200 | 010015 | | | PO T | rawe | r B. | Den | ton. N | farv1 | and | 21629 |
| 15 10 | 23. PART I. Enter the diseases, or p ahock, or heart failure/ I | omplications the | t coused the de | eth. Do r | not ente | r the mo | de of dyl | ng, sucl | h an card | liac or reapi | ratory arre | eat, | Approximata |
| | IMMEDIATE CAUSE (Final | | | • | | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | me | or as a consect | 在方 | c 1 | lun | 9 | Car | ce | r | | | 10 month. |
| | | DUE TO | (OR AS A CONSEC | DUENCE O | F): | , 0 | | | | | | | |
| Z | Sequentially list conditions, | | | | | SUF | 2 | | | | | | |
| E | if any, leading to immediate | DUE TO | (OR AS A CONSEC | DUENCE O | F): | | | | | | | | |
| ERTIFICATION | CAUSE (Disease or injury | ¥ | | | | | | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO | (OR AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| | | d, | | | | | | | | | | | |
| C | PART II. Other aignificant conditions | n contributing to | deeth but not n | esuiting | In the u | nderlying | ceuse g | iven in | Part i. | 24a. WAS AN | AUTOPSY | 24b. WF | RE AUTOPSY FINDINGS |
| MEDICAL | COPO, | | | | | | | | | PERFOR | MED? | AM | AILABLE PRIOR TO |
| | | | | | | | | | | 1 TES 2 | KNO | OF | DEATH? |
| ≥ | | | | | | | | | - | | | 1 [| YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26 PI | ACE OF DE | EATH (Cha | not and an | -1 | | | |
| 18 | EXAMINER? 1 YES 2 NO | HOSPITAL: | EB/Output a | □ pos | OTHE | R: | | | | | | | |
| ¥ | 27, MANNER OF GEATH | 28e, DATE OF | | 28b. TIM | | 28c. INJ | | sidence | | (Specify) CRIBE HOW IN | HIM OOM | 1050 | |
| | 1 Natural 5 Pending | (Month, Di | | INJ | URY | WO | RK? | 140 | 280. DES | CHIBE HOW IN | IJUHY OCCI | DHED | |
| BY | 2 Accident Investigation 3 Suicide 6 Could and be | 28e. PLACE O | F INJURY — At hor | me ferm i | ttroot for | | | - | 201 1 000 | TION (Street o | and Advantage of | 0 1 0 1 | |
| <u> </u> | 4 Homicide 6 Could not be | building, | etc. (Specify) | ,, | revenue, ran | itory, orne | ' | | City o | ATION (Street a or Town, State) | na Number o | r Hunii Houti | Number, |
| 9 | 29a. CERTIFIER | | | | | | | | | | | | |
| COMPLET | (Check only 1 PC CENTIFYING PHYSIC | | | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINER | 4 | kamination and/or i | nvestigatio | n, in my | opinion, de | eath occur | ed at the t | time, date | and place, and | due to the | cause(a) an | d manner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 / | | 14.4 | 0 | | 29c. LICE | 444 | | | 29d, DATE | SIGNED (Mo | onth, Day, Year) |
| 0 | | 16 | | | <u>.</u> | | D | 33- | 768 | | A | 9 14 | , 1995 |
| I F | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | SE OF OFATH (ITEM | 4 27) /Kma | Deint | | | | | | | | - |

in, M.D., Daffir 32/hegistnan's signature Juna Davidson-Aindese

Daffin Lane, Denton, Maryland

Corwin,

James E.



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| NON | R. Aft | 60 |
| ATTE | ECTO afte | n 28 |
| O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | L DIR | Iten |
| SPITA | VERAI | 11:11 |
| E HO | E FUI | RTA |
| TH O | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filled within 72 hours after death with the State Debt. of Health and Mental Moviene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| | | |

DIRECTOR

FUNERAL

BY

COMPLETED

BE

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CERTIFICATION

MEDICAL

PHYSICIAN:

ВҮ

COMPLETED

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2

1 TES 2 NO

5 Pending Investigation

8 Could not be

27. MANNER OF DEATH

1 Natural

2 Accident

4 Homicide

3 Suicide

95 27464 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH August 24 1995 ELZIE DEAN **OSBORNE** 5:15 pm 4. SOCIAL SECURITY NUMBER 5. SFX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year, Dec. 7 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 220-14-5385 DAYS HOURS NX M 2 | F 70 YRS. 1924 North Carolina 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5313 Linkwood Road Linkwood Dorchester RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Linkwood 1 YES 2 TONO 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5313 Linkwood Road 21835 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 12 YES 2 NO 1 Never Married 2 X Married 1 YES 2 X NO Specify: Specify: 3 Widowed 4 Divorced white 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 10 truck driver transportation 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lester Franklin Osborne Inez Huffman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruby S. Osborne P.O. Box 2, Linkwood MD 21835 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Maryland Veterans Cemetery 8/28 Hurlock Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home smeth R 700 Locust St., Cambridge MD 21613 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition ARREST. CARDIOPULMONARU resulting in death) DUE TO (OR AS A CONSEQUENCE OF): repatocellular CARCINOMA Cours Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a, WAS AN AUTOPSY PERFORMED? 1 TES 2 NO

28f. LOCATION (Street and Number or Rural Route Number City or Town State)

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?**

| 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
|--------------------------------------|------------|------------|--------------|------------------|--|--|--|--|--|
| OSPITAL: Inpetient 2 ER/Outpetient 3 | OTHE | | 5 KRasidenca | 8 Other (Specify | | | | | |
| 28a. DATE OF INJURY 26 | b. TIME OF | 28c. INJUR | | 28d. DESCRIBE HO | | | | | |

M 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify)

BE HOW INJURY OCCURED 1 YES 2 NO

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one)

| 2 MEDICAL EXAMINER: On the besis of axamination end/or in | investigation, in my opinion, death occured at the time, data and place | is, and due to the cause(s) end manner as stated. |
|-----------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |

VIDA

| | VVV | ice | | | | 12400 | 0 | |
|---------------------------|------------------------|--------------|-------------------|------------------------|--------|------------|------|--|
| 30. | NAME AND ADDRESS OF PE | RSON WHO COM | PLETED CAUSE OF D | DEATH (ITEM 27) (Type, | Print) | | | |
| ~ | KIRNEN | MI | (100) | Buch | GT. | (a landa | Md | |
| $\underline{\mathcal{L}}$ | 7-110-61 | 11.0 | TUO | DURIV | 21. | Can priace | 1110 | |

31. DATE FILED (Month, Day, Near). 8 1995 July Muchan Raydall 38

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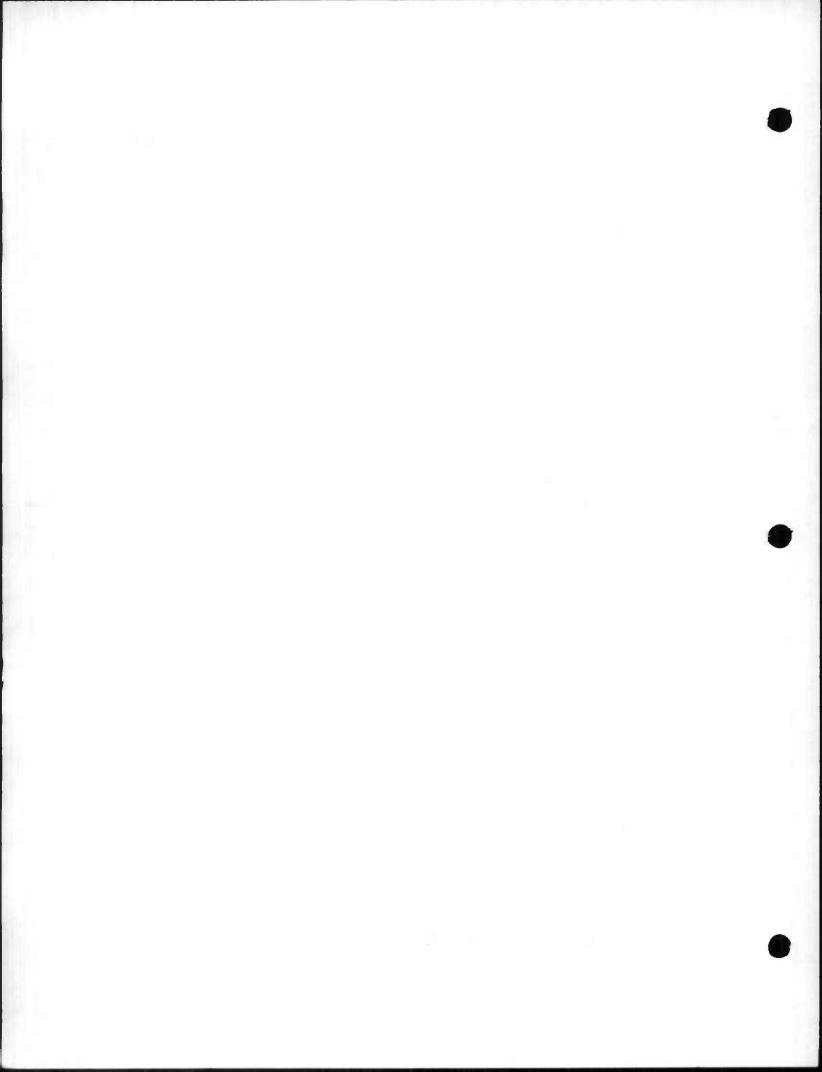
28

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the retained by the stending physician.

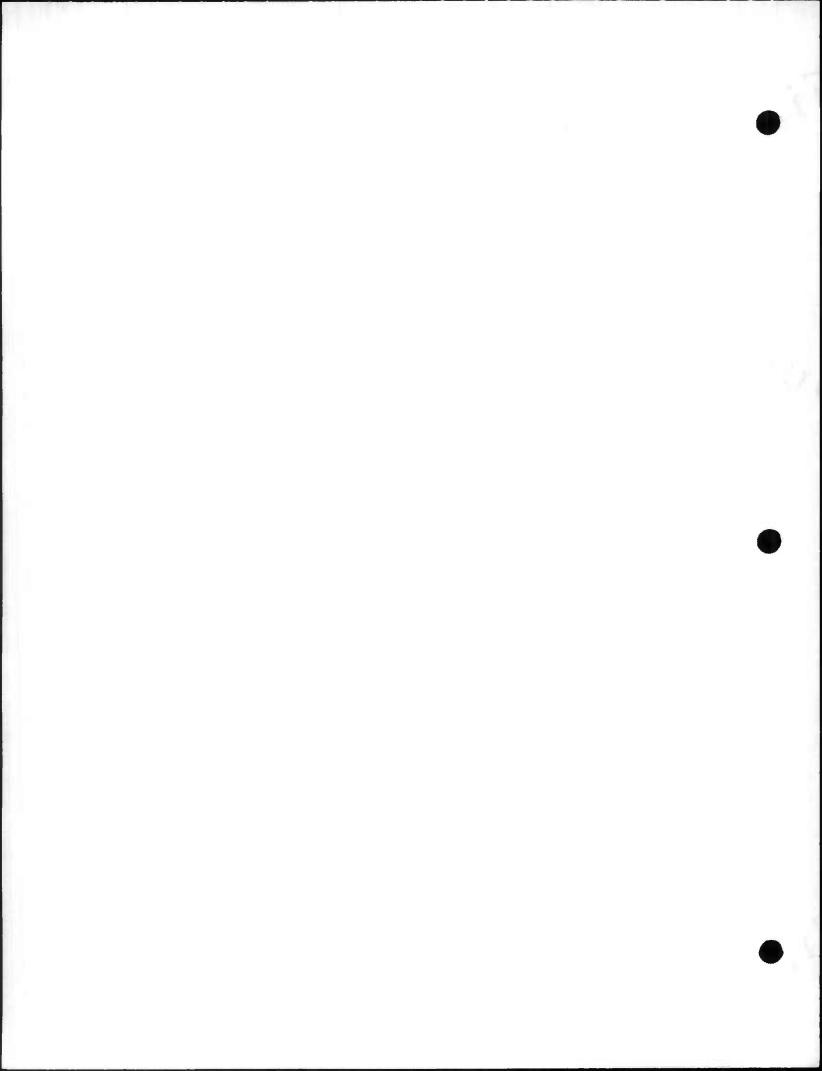
TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | HEGISTHAR | | - | FILL | ICATE U | F DEATH | | REG. NO | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | MONT | OF DEATH | AY | | TIME OF OEATH |
| | Margaret Rose 1 | - | | | | | Au | ig 7 | 1 | 995 | 5:30 а м |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. I | sat birthday) | IF UNDER 1 YEA | | | OF BIRTH | | 8. BIRTHPL Country) | ACE (State or Foreign |
| | 220-56-1981 | 1 □ M 2 🙀 F | 36 | YRS. | months dat | - HOURS W | June 30, | | | | land |
| _ | Se. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COU | NTY OF OEAT | гн |
| Ö | 18350 Henderson I | Road | | | Marydel | | | | Caroline | | |
| <u>ଅ</u> | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | 100 000 | CITY, TOWN OR LOCATION 104 II | | | | | | | | |
| <u>E</u> | | Oline | | | | CHION | | | | | d. INSIDE CITY LIMITS? |
| 5 | 10e. STREET AND NUMBER | TILLE | | Ma | rydel | | | | | | YES 2 NO |
| FUNERAL DIRECTOR | | 20.01 | | | İ | 101, ZIP CODE | | | | | T COUNTRY? |
| 밀 | 18350 Henderson Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | | | | | 216 | | | | J.S.A. | |
| 5 | 1 Never Married 2 Married | FORCES? 1 | YES 2X | | It yes, | DECENOENT OF HIS | exican, Puerto | 77 (Specify Yes Rican, etc.) | or No- | 14. RACE — Black, V | American Indian, /hita, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 10 | ES 2X NO S | pecify: | | | Specify | hite |
| | 15. OECEDENT'S EDU | ICATION | 18a, C | ECEDENT'S | USUAL OCCUP | ATION | 161 | KIND OF BU | SINESS /IND | | |
| E | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | | Give kind of vie. Do NOT us | vork done during e retired.) | most of working | 1 | . KIND OF BO | JINC 33/IND | OSINI | |
| 4 | 10 | College (1-4 or 5+) | | rses a | assista | int | l n | ursing | home | 9.0 | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | S NAME (First. | | | | |
| BE C | Joseph Betch | | | | | Rose | Galli | on Bet | ch | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADDRESS (Stre | et and Number or R | | | | Code) | |
| 2 | John Betch | | | | | s Road | | | | | 21640 |
| | 20a. METHOD OF DISPOSITION 1 Disposition 3 Rem | Contract Vision | 20b. PLACE | ANDDATEC | F OISPOSITION | (Name of | DAT | - Y | | City or Town, | |
| | 4 Donation 5 Other (Specify) | lovel from State | Car | oital | Cremat | ory | 8/ | B Do | ver. | Delaw | are |
| - 1 | 21. SIGNATURE OF TUNERAL SERVICE LI | CENSEE | | | | AND ADDRESS OF | | | | | |
| | Men (| T | Ce- | 1 | Flee P.O. | gle-Heli Box 160 | fenbei: | n Fune | ral H | lome rvlan | d 21639 |
| | 23. PART I. Enter the diseases, or | complications that | caused the d | eath. Do n | ot enter the | mode of dying, | auch as can | lisc or respi | retory arr | est, | Approximata |
| | shock, or heart fellure. IMMEDIATE CAUSE (Final | List only one caus | e on each iln | e. | | | | | | | Interval Between Onset and Daath |
| | disease or condition resulting in death) | . 64 | 10 1 | SLH | STO | mA | MA | ILT | 1F01 | 2ME | 21/ |
| i | rooting in deathy | DUE TO (| OR AS A CONSE | | | | | | | | 4 |
| Z | Sequentially list conditions, | b | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate | OUE TO (| OR AS A CONSE | OUENCE OF |): | | | | | | |
| 일 | cause. Enter UNDERLYING CAUSE (Disease or Injury | C. | | | | | | | | | |
| E | that initiated events resulting in death) LAST | DOE 10 (| OR AS A CONSE | QUENCE OF |): | | | | | | |
| 8 | | d | | | | | | | | | |
| | PART II. Other aignificant condition | ns contributing to | leeth but not | resulting I | n the underly | ing cause given | in Part I. | 24a. WAS AN | | | RE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | PERFOR | 9.00 | CO | MILABLE PRIOR TO MPLETION OF CAUSE |
| MEC | | | | | | | | 1 123 4 | /Ly no | | DEATH? |
| = | | | | | | | | | | | 20 2 |
| | | | | | | | | | | | |
| <u></u> | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. | PLACE OF DEATH | (Check only on | •) | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient | 3 DOA | OTHER: | PLACE OF DEATH | | | | | |
| HYSICIA | EXAMINER? | 1 D Inpatient 2 D | NJURY | 28b. TIME | OTHER: 4 Nursing H | ome 5 Cheelden | nce 6 🗆 Othe | | NJURY OCC | URED | |
| Y PHYSICIAN: | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 | NJURY | | OTHER: 4 Nursing H | ome 5 Cheelden | 28d. DES | r (Specify) | NJURY OCC | URED | |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | 28e. DATE OF P (Month, Day 28e. PLACE OF | NJURY (, Year) INJURY — AI h | 28b. TIME | OTHER: 4 Nursing H OF 28c, JRY 1 | injury at work? | 28d. DES | (Specify) CRIBE HOW II | | | o Number, |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28e. DATE OF P (Month, Day 28e. PLACE OF | NJURY (, Year) | 28b. TIME | OTHER: 4 Nursing H OF 28c, JRY 1 | injury at work? | 28d. DES | r (Specify) CRIBE HOW II | | | o Number, |
| B≼ | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be detarmined | 1 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Dinpatient 2 Din | NJURY , Year) INJURY — At h tc. (Specify) | 28b. TIME INJU | OTHER: 4 Nursing H E OF 28c. JRY M 1 [Ireet, factory, or | iome 5 Aseiden INJURY AT WORK? YES 2 NO | 28d. DES | T (Specify) CRIBE HOW II ATION (Street a for Town, State) | ind Number | or Rural Route | » Number, |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFYING PHYS | 28e. DATE OF Parameter (Month, Day 28e. PLACE OF building, e | NJURY , Year) INJURY — Al h Ic. (Specify) | 28b. TIME INJI ome, farm, s | OTHER: 4 Nursing H E OF 28c. JRY M 1 [Rreet, factory, or | NJURY AT WORK? YES 2 NO | 28d. DES | r (Specify) CRIBE HOW II ATION (Street a or Town, State) | nd Number | or Rural Route | |
| COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYS | 28e. DATE OF I (Month, Da) 28e. PLACE OF building, e | NJURY , Year) INJURY — Al h Ic. (Specify) | 28b. TIME INJI ome, farm, s | OTHER: 4 Nursing H E OF 28c. JRY M 1 [Rreet, factory, or | NOME STARREST | 28d. DES | r (Specify) CRIBE HOW II ATION (Street a or Town, State) | nd Number | or Runil Route | d manner as stated. |
| BE COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEOICAL EXAMINE | 28e. DATE OF I (Month, Da) 28e. PLACE OF building, e | NJURY , Year) INJURY — Al h Ic. (Specify) | 28b. TIME INJI ome, farm, s | OTHER: 4 Nursing H E OF 28c. JRY M 1 [Rreet, factory, or | NJURY AT WORK? YES 2 NO | 28d. DES | r (Specify) CRIBE HOW II ATION (Street a or Town, State) | nd Number | or Runil Route | |
| COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEOICAL EXAMINE | 28e. DATE OF a (Month, Day 28e. PLACE OF building, e | NJURY (, Year) INJURY — All http://doi.org/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10 | 28b. TiMi INJI | OTHER: 4 □ Nursing H E OF JETY M 1 [Itreet, factory, or d at the time, d 1, in my opinior | NOME STARREST | 28d. DES | r (Specify) CRIBE HOW II ATION (Street a or Town, State) | nd Number | or Runil Route | d manner as stated. |
| TO BE COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide 6 CERTIFYING PHYS (Check only one) 2 MEOICAL EXAMINE 30. NAME AND ADDRESS OF PERSON WHAT A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROPERTY A PROP | 28e. DATE OF a (Month, Day 28e. PLACE OF building, e | NJURY (, Year) INJURY — All http://doi.org/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10 | 28b. TiMi INJI | OTHER: 4 □ Nursing H EOF 28c. JRY M 1 [Itreet, factory, or d at the time, d 1, in my opinior | NOME STARREST | 28d. DES 28d. LOC City due to the cau the time, data NUMBER 3 | T (Specify) CRIBE HOW H ATTON (Street a per Town, State) se(a) and man and place, an | ner se state d due to the | or Rural Route ed. couse(a) an | d manner as stated. Day, Year) |
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be find within 72 hours after death with the State Dear of Heath and Mental Monine prior to burial commandon or removal | IMPORTANT. If them 28 is marked, or from 23 shows any Injury, or other traumatic event, the medical examiner must be notified |
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| | 1 - FOR REGISTRAR | STATE OF MARY | | RTMENT OF | | | YGIENI | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | DEATH | | T | 3. TIME OF DEATN |
| | Mildred | Magdeline | Pe | nningto | on | Augus | st 9 | 199 | YEAR | 11:13P M |
| 1 | 110000 | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | | 199 | | |
| | | 1 M 2 F | | MONTHS DAYS | HOURS MIN. | (Month, De | | | 6. SIFTHE | PLACE (State or Foreign |
| | <u> </u> | X | 72 YRS. | | | January | 29, 1 | 1923 | Mary | yland |
| - | 9a. FACILITY NAME (If not institution, give stre | et and number) | | 9b. CITY, TOWN | OR LOCATION OF DE | EATH | | 9c. COUN | TY OF DE | ATN |
| Ö | Memorial Hospital | | | Easto | n | | | Tall | oot | |
| [| 10s. STATE 10b. COUNTY | | 170 | | | | | | | |
| DIRECTOR | | | | Y, TOWN OR LOCA | ATION | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Carol | <u>ine</u> | I | enton | | | TX YES 2 NO | | | TES 2 NO |
| ₹ I | 10e. STREET AND NUMBER | | | 10 | H. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY | | | HAT COUNTRY? |
| FUNERAL | 213 South Eighth | Street | | | 21629 | | | U.S | 5.A. | |
| 5 | | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS DE | CENDENT OF NISPAN | VIC ORIGIN? (S | pecify Yes | or No- | 14. RACE | - American Indian, White, etc. |
| BY F | 1 Never Married 2 Married | IF YES, GIVE WAR OR | DATES | | pecify Cuban, Maxica S 2 NO Specifi | | n, etc.) | | Specify | |
| | 3 Widowed 4 Divorced | | | | | | | | , , , | casian |
| 9 | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION ompleted) | 16a. DECEDENT'S | USUAL OCCUPATI | ION | 16b. KIN | O OF BUS | INESS/IND | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | se retired.) | ost or working | | | | | |
| P P | 11 HS grad. | | Cler | k | | Gov | ernm | ent/1 | Media | a |
| COMPLET | 17. FATNER'S NAME (First, Middle, Lest) | | | | 18. MOTNER'S NA | | | | | |
| BE (| James Ear | 1 Walters | | | Edith | Magda 1 | ine | Worth | 1 | |
| | 19a. INFORMANT'S NAME (Type/Print) | 11020020 | 19b. MAILING | ADDRESS (Street | and Number or Rural I | | | | | |
| 유 | Philip Walters | | | | oad, Mill | | | | | 270 |
| | 20a, METNOD OF DISPOSITION | 200 | b. PLACE AND DATE | | | | | | | |
| | 1 Burlai 2 M Cremation 3 Remove | ral from State ce | v. crematory or o | ther place) | | OATE | | | | |
| | 4 Donation 5 Other (Specify) | 1000 D | istern Sr | ern Shore Crematorium 8/1 | | | 10 Georgetown, Delaware | | | |
| at trame and aboness of Paciety | | | | | | D 3 | | | | |
| Moore Funeral Home, P.A. PO Drawer B, Denton, Maryland 21629 | | | | | | 21629 | | | | |
| | 23. PART I. Enter the diseases, of col | mplications that cause | d the death. Do | not enter the mo | ode of dving, auc | h as cardiac | or reapir | atory arre | ent. | Approximate |
| 1 1 | snock, or neert reliure. List only one ceuse on each line. | | | | | | | | | |
| 1 1 | | at only one couse on | ech line. | | , | The Carolino | | 17.0 | | Interval Batween |
| | IMMEDIATE CAUSE (Final | | | | | Trade Carolino | | | | Interval Batween Onset and Death |
| | IMMEDIATE CAUSE (Final | Coagulor | athy | | | | | | | Interval Batween |
| | IMMEDIATE CAUSE (Final | Coagulor | | | | - au carolac | | | | Interval Batween Onset and Death |
| NO | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | Coagulor DUE TO (OR AS | athy A CONSEQUENCE O | F): | | | | | | Interval Batween Onset and Death |
| ATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | Coagulor DUE TO (OR AS | athy | F): | | | | | | Interval Batween Onset and Death |
| CATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | Coagulor DUE TO (OR AS | eathy A CONSEQUENCE O | F): | | | | | | Interval Batween Onset and Death |
| MIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | Coagulor DUE TO (OR AS | athy A CONSEQUENCE O | F): | | | | | | Interval Batween Onset and Death |
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| 1 - 1 | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions | COAGULOR DUE TO (OR AS DUE TO (OR AS Contributing to deeth | A CONSEQUENCE O | F): F): In the underlyIn | ig cause given in | Part I. 24a | . WAS AN A | WITOPSY | 246.1 | Interval Batween Onset and Death 9 days WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| 1 - 1 | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions Malnutrition, | COAGULOR DUE TO (OR AS DUE TO (OR AS Contributing to deeth | A CONSEQUENCE O | F): F): In the underlyIn | ig cause given in | Part I. 24a | . WAS AN A | NUTOPSY MED? | 24b. 1 | Interval Batween Onset and Death 9 days |
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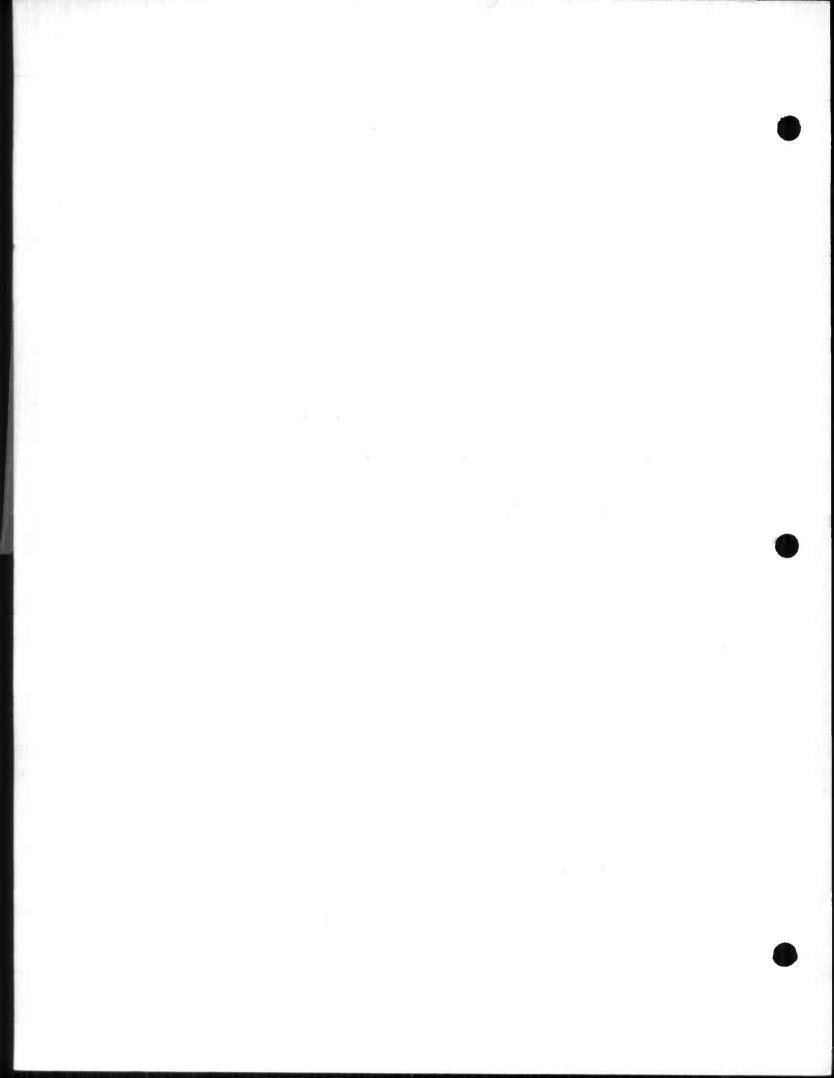
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Poer filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumalle event, the medical examiner must be notified at once. |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | STATE OF MARY | | | | HEALTH AND F DEATH | MENTA | L HYGIENI REG. NO. | E | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------|----------------|----------------|-------------------------------------------|-----------|-----------------------|---------------|------------|-----------------------------------------------|---------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE | OF DEATH | u 4- | 3. | TIME OF DEA | TH |
| DELORES | JEAN | | POLO | MSKE | Y A | | ST 21 | | | 5:45 | Рм |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last | | ONTHS DAYS | | (Monti | OF BIRTH | - 1 | BIRTHPL | ACE (State or F | oreign |
| 314–56–2399 | 1 - M 2/F | 44 | YRS. | ONTHS DAYS | HOURS MIN. | Jan | 14 19 | 51 | ,, | Michie | gan |
| Se. FACILITY NAME (If not institution, give street | et and number) | | 9 | b. CITY, TOW | N DR LOCATION OF D | EATH | | 9c. COUNTY | OF DEAT | TH | |
| BREEZY POINT MA | RINA | | | | APEAKE E | BEAC | H | CAL | VER | T | |
| MD 106. STATE 106. COUNTY | Calvert | | | nesape | ake Beach | 1 | | | | LIMITS? | |
| 10e. STREET AND NUMBER | | | | | 0f. ZIP CODE 10g. CITIZEN OF WHAT | | | | T COUNTRY? | | |
| 4883 Ridge Road | d | | | | 2073 | 32 | | | U.S | S.A. | |
| | 12. WAS DECEDENT EVER FORCES? 1 YES | | | | ECENDENT OF HISPA specify Cuben, Mexic | | | or No- 14. | RACE - | American Ind | len, |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | | | ES 2 [X] NO Speci | | | | Specify: | white | |
| 15. DECEDENT'S EDUCA (Specify only highest grade co | TION ompleted) | (G/s | re kind of wor | SUAL OCCUPA | TION most of working | 16b | . KIND OF BUS | HESS/INDUST | TRY | | |
| | College (1-4 or 5+) | | Do NOT use I | | lelenomone | | Datail | (Den see) | | Tourism (| Cala |
| 12 | | ACC | ountai | nt/Boo | kkeeper | | Retail | | . & 1 | dib. | Sares |
| 17. FATHER'S NAME (First, Middle, Last) | | D- ' | 11 | | 18. MOTHER'S N. | | _ | , | 1 | | |
| Harry 19a, INFORMANT'S NAME (Type/Print) | | | lomske | ** | | lores | | | - | | |
| Delores Jean Pol | omekov | 196 | | | nt and Number or Rural | | | | - | | |
| 20a. METHOD OF DISPOSITION | - | AL DI 4054 | | DISPOSITION | | DAT | - | CATION — City | _ | Cana. | |
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| / | 1.11 | | | | | | - | | | | |
| 23. PART I. Enter the Measure, or co | 10/1 | | | | ch Funera | | | | | MD 20 | /36 |
| shook of heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in desth) | Oan | | UENCE OF): | | | | | | | Onest an | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| PART II. Other significant conditions | contributing to death | but not re | esuiting in | the underly | ring ceuse given in | n Part i. | 24s. WAS AN PERFOR | MED? | AN CC | ERE AUTOPSY MILABLE PRIOR DEPLETION OF DEATH? | CAUSE |
| DID TOBACCO USE CONTRI | BUTE TO CAUSE | OF DEA | TH YES | □ NO | ☐ UNCERTA | IN 🗆 | | | | | |
| | HOSPITAL: | | | (Check only or | | e Now | es (Specific) | TNI MA | משידי | | |
| 27. MANNER OF DEATH | 1 | | 26b. TIME | OF 28c. | ome 5 Residence | | SCRIBE HOW I | | TER | siect | |
| 1 Netural 5 Pending | (Month, Day, Year, | raun | 1700 | RY | WORK? | ara | | , , | | wher | |
| 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE OF INJU | RY — At ho | | | | 28f. LOC | CATION (Street a | | | | |
| 4 Homicide 6 Could not be | building, etc. (Sp | | larir | | | 0 | or Town, State) | Punt | 1 | narihe | |
| 29s, CERTIFIER | MI To the Association Law | | | | | 10. | 9 | 70 | | 1000110 | ~ |
| (Check only one) 2 MEDICAL EXAMINER | IAN: To the best of my kno : On the basis of examinat | | | | | | | | ause(s) a | nd menner as | stated. |
| 29b. SIGNATURE AND THE OF CERTIFIER | PALL | | | | O . C . N | | Δ | 29d. DATE S | | onth, Day, Year | |
| 30. NAME AND ADDRESS OF PERSON WHO DW A ST. DATE FILED (Month, Day, Year) AUG 25 1995 | COMPLETED CAUSE OF I | 111 | Penr | | eet, Ba | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| E. Tanman 15 Franklin Street Cambridge, MD 21613 31. DATE FILED (Month, Day, Year) AUG 2 5 1995 AUG 2 5 1995 | F | | | | int) | : | - | | | | |
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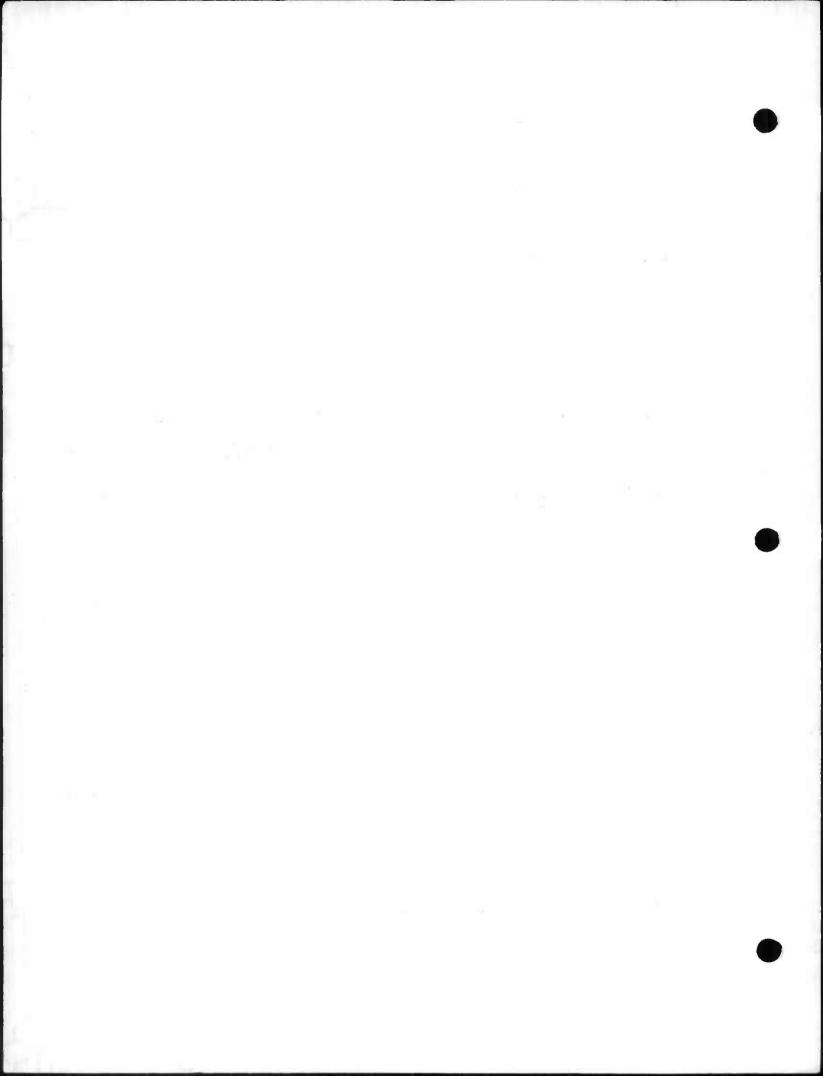
the burlal-transit permit. Pages 1, 2, 3 should retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 page 5 should be detached for use as nours after death. Page 6 may be funeral director, filled in by the completely DIVISION OF VITAL RECORDS, P.O. BOX 68760 this certificate has been signed by the attending physician and a with the State Dept. of Health and Mental Hyglene prior to buni HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

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DIRECTOR: After hours after death

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH DAY 3. TIME OF DEATN YEAR EDITH GAY POLING 1995 August 11:10 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN
(Month, Day, Year)
Apr. 5, 1924 B. BIRTHPLACE (State or Foreign Country)
West Virgin 6. AGE (In yrs. last birthday DAYS 1 M 2 F 233-52-3624 Virginia 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SACRED HEART HOSPITAL CUMBERLAND ALLEGANY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY CORRIGANVILLE 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 112/5 N. CONCORD AVENUE U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Maxicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER HOME 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname, ELLIS BRYAN IDA HALLER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 P.O.BOX 307 - CORRIGANVILLE, MD RONALD DELANO POLING 21524 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 1 X Buriel 2 Cremetion 3 Re MOATSVILLE, WV SHILOH CEMETERY 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE FORMAN FUNERAL HOME STEMPLE AND P.O.BOX 280-PHILIPPI, WV 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Fine) Onset and Death Vy 51 ky Phonix disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL billy willeties 1 TES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 | Inpetient 2 | XER/Outpetient 3 | DOA OTHER: 1 TES 2 () ND 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked 1 X Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Item 28 is COMPLETED 8 Could not be 4 Nomicide 29a. CERTIFIER 1 🖔 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 ho 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 8/22/50 321244 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) JESUS TAN, M.D. - FROSTBURG PLAZA, FROSTBURG, MD REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)



DHMH-16 Rev 1/89

| I THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. I THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. |
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| | 1 - STATE REGISTRAR | STATE OF M | MARYLAND C | / DEPAR | TMENT | OF HEALI | H AND | | IYGIENE IEG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF | DEATN | | | 3. TIME OF DEATN | |
| | MARGARE | T PITTMA | 1/12 | | | | | MONTH | DAY | 4 | YEAR | 06:20A | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | ast birthday) | IF UNDER 1 | YEAR IF UN | DER 24 HRS. | AUG UST | SIRTN | | 995 | LACE (State or Foreign | |
| | 577 - 60 - 4841 | 1 M 2 F | 94 | YRS. | MONTHS | DAYS HOUR | S MIN. | Jan. | 200 19 | 01 | Country) | ansas | |
| | 9e. FACILITY NAME (If not institution, give si | treet and number) | | | Sh CITY I | OWN OR LOC | TION OF D | | | | | | |
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| 16 | Prince Georges Ho | spital Ce | enter | | Che | verly | | | | Pr | ince | George | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | | | | | | od, INSIDE CITY | | | | |
| 1 2 | Maryland Prin | ce George | es | Fo | restv | ille | | | | YLIMITS? | | | |
| 7 | 10e. STREET AND NUMBER | | | | | 10f. ZIP C | ODE | | 10 | On. CITIZ | EN OF WH | AT COUNTRY? | |
| 8 | 7420 Marlboro Pike 20747 | | | | | | | | | | S.A. | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT | T EVER IN U.S. A | BMED | 13 W | S DECEMBEN | T OF MISPA | NIC OBIOINS (6 | and Was as | | | A | |
| | 1 X Never Married 2 Married | FORCES? 1 IF YES, GIVE W | YES 2 | NO | 11/2 | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Moxicen, Puerto Ricen, etc.) 1 — YES 2 X NO Specify: Specify: | | | | | – American Indian, White, etc. | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE W | AH OH DATES | | 1 '' | J YES 2 XJ I | O Specif | ly: | | | Specify. | white | |
| | 15. DECEDENT'S EDUC | CATION | 16e, D | ECEDENT'S | USUAL OCC | UPATION | | 16b. KIN | D OF BUSINE | ESS/IND | USTRY | | |
| li, | (Specify only highest grade Elementary/Secondary (0-12) | vork done du e retired.) | ing most of wo | rking O-E | 200 | | | | tute Of | | | | |
| . 교 | 12 | College (1-4 or 5+ | | | | ector | OL | | ealth | | | | |
| COMPLET | 12 ST Microbiology Hea | | | | | | | | | | | | |
| BEC | James Pittman, M.D. Virginia Alice McCormick | | | | | | | | | | | | |
| 8 | 10. INFORMANT'S NAME (Toursday) | | | | | | | | | | | | |
| 2 | Mary Virginia Pittman-Waller 10405 Glenmore Drive Adelphi, Maryland 20783 | | | | | | | | | | | 20783 | |
| 5 | 20a. METHOD OF DISPOSITION XX 20b. PLACE AND DATE OF DISPOSITION /Name of | | | | | | | | | | | | |
| | 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Henric 4 ☐ Donalion 5 ☐ Other (Specify) | | | | | | | | | | | | |
| TO BE COM | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | | | neral H | | | LOVE | ALKalisas | |
| | * (newax | 1/ 1 | | | | | | | | | | | |
| | W- | 4 4 | | | 31 | 3 Talb | ott A | venue | Laure | eT, | Mary | land 20707 | |
| | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only pie cause on each line. Approximate interval Batween | | | | | | | | | | | | |
| | Interval Dates | | | | | | | | | | | Onset and Death | |
| | | | | | | | | | | | | 2 weeks | |
| CAGILL, | | DUE TO (| (OR AS A CONSE | | | 0.0. | 540 64 | 0.5 | 1 | | | 1 year | |
| TIFICATION | Sequentially list conditions, | A. Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commerci | | | | +K DI | b W A | OPAT | нч | | | 17001 | |
| F | If any, leading to immediate cause. Enter UNDERLYING | OUE 10 (| OR AS A CONSE | EOUENCE OF | -): | | | | | | | | |
| | CAUSE (Disease or Injury | DUE TO (| OR AS A CONSE | EQUENCE OF | | | | | | | | | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | | (011110111001100 | | ,- | | | | | | | į | |
| | | l | | | | | | | | | | | |
| AL CE | PART II. Other algnificant conditions | | | | | | | Part I. 24s | . WAS AN AUT | | | ERE AUTOPSY FINDINGS | |
| | Cere brovascula | ir disea | ase, D | rabe | tes K | hellit | Vi | 1,, | PERFORME | - | C | WAILABLE PRIOR TO OMPLETION OF CAUSE | |
| MEDICAL | Repal insuffic | ciency | , | | | | | _ ' | 7 | | | F DEATH? | |
| ż | DID TOBACCO USE CONTR | IBUTE TO CAI | USE OF DEA | ATH YE | S 🗆 N | JU UN | CERTAII | N 🗆 | | | 1 | - I - I - I - I - I - I - I - I - I - I | |
| NAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | CE OF DEAT | | / 1 | | | | | | | |
| YSICI | 1 Tes 2 X No | HOSPITAL: | ER/Outpatient | 3 DOA | OTHER: | Nome 5 | Residence | 6 Other (Sp. | nc/fv) | | | | |
| | 27. MANNER OF DEATH | 28e. DATE OF | INJURY | 28b. TIMI | E OF 2 | ic. INJURY AT | | 28d. DESCRIE | | RY OCC | UREO | | |
| BY PI | 1 Natural 5 Pending 2 Accident Investigation | (Month, Da | y, romij | in/J | URY M | WORK? | □ NO | | | | | | |
| | 3 Suicide 8 Could not be | 26e. PLACE OF | F INJURY — At h | ome, ferm, s | treet, lectory | , office | | 281. LOCATIO | N (Street and I | Number o | or Rural Rou | te Number, | |
| 9 = | 4 Homicide determined | burraning, | oral (apoonty) | | | | | City or To | vn, State) | | | | |
| P.E. | 290. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of r | my knowledge, d | leath occurre | d at the time | , date and pla | ce, and due | to the councie | and menner | no pinte | d | | |
| - Z | one) 2 MEDICAL EXAMINER | | | | | | | | | | | nd menner se stated. | |
| 0 17 | | | | | | | | | | | 4-7 | | |
| BE COMPLE | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | 29c. 1 | CENSE NUI | MBER | 20 | d DATE | SIGNED 4 | fonth, Day, Year) | |

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

| 1 | | FOR STATE REGISTR | ΑЯ |
|---|------|-------------------------|----|
| | 1. D | ECEDENT'S | NA |

| | 1 - STATE REGISTRAR | C | ERTIF | CATE OF | DEATH | AE | G. NO. | | | | | |
|---------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------|------------------|---------------------|---------------------------------------------------------------------|----------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF O | EATH | VELO | 3. TIME OF C | DEATH | | |
| | Elizabeth B | Preston | | | | Augus | st 21. | 1995 | 10:40 | P.M. | | |
| R | 4. SOCIAL SECURITY NUMBER 2.15-26-6849 1 □ M 2 | 6. AGE (In yrs. le | est birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dev. Year) May 20, 1928 | | | HPLACE (Stote of | or Foreign | | |
| | 90. FACILITY NAME (If not institution, give street end num 20 Howard Sta | iber) | | | | | | | any | | | |
| E 1 | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| DIRECTOR | Maryland 106. COUNTY Maryland Allegany | | | y, town or locat Frostbur | | | | 10d. INSIDE LIMITS? | , | | | |
| FUNERAL | 100. STREET AND NUMBER 20 Howard Stree | t | | 101 | 21532 | | 10g. | WHAT COUNTR | ty? | | | |
| BY | 1 Never Married 2 M Married FORCE | ECEDENT EVER IN U.S.A.ES? 1 TYES 2.E., GIVE WAR OR DATES | RMED NO | | ENDENT OF HISPAN polity Cuben, Mexican 2 NO Specify | n, Puerto Ricen | | Blac | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| B | 15. DECEDENT'S EDUCATION | | | USUAL OCCUPATIO | | 16b. KINI | OF BUSINESS | S/INDUSTRY | | 7 | | |
| Ē | (Specify only highest grade completed) Elementary/Secondary (0-12) College (| 1-4 or 5+) | te. Do NOT us | | st or working | | | | | | | |
| 4PL | 12 | 2 | Home | maker | ne | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) | | | | | | | | | | | |
| BE (| Clive W. Jan | es | | Grace Winters | | | | | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) T. William Preston | 1 | 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20 Howard Sta, Frostburg, Md. 21532 | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1/ Burlel 2 Cremetion 3 Removal from 5 4 Donation 6 Other (Specify) | 20b. PLACI cemetery, c | | ANDDATE OF DISPOSITION (Name of page tory or other place) By 25 Prostburg, Md. | | | | | | | | |
| | 21. SHOME AND ADDRESS OF FACILITY 57 FYOST AVE. | | | | | | | | | | | |
| | John F. Horn | / | | | | | | | rg, Md. 21532 | | | |
| | 23. PATY I. Enter the disesses, or complication shock, or heart failure. List only | one cause on each li | death. Do r | not sitter the mo | ds of dying, suc | h ss cardisc | or respirator | y srrest, | | ximats ai Between | | |
| | HAMEDIATE CALLOR (FI) | | | , | 4 | | | • | | and Death | | |
| | disease or condition resulting in death) | ar ciner | ea | Lung. | with | heest | istas | 5 | 3 | mos | | |
| | | OUE TO (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| Z | Sequentisity list conditions, | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate | DUE TO (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Diseese or Injury | DUE TO (OR AS A CONS | EOHENCE O | E). | | | | | | | | |
| Ë | that initiated events resulting in death) LAST | DUE TO (OH AS A CONS | ECOENCE O | r). | | | | | İ | | | |
| Ä | d | d | | | | | | | | | | |
| 1 | PART II. Other significent conditions contribu | iting to deeth but not | t resulting | in the underlyin | g ceuee given in | Port I. 24a | WAS AN AUTO | PSY 24 | b. WERE AUTOP | | | |
| DICAL | | | | | | 16 | YES 2 N | | COMPLETION OF DEATH? | | | |
| | | | | | | | | | 1 TYES 2 | NO NO | | |
| PHYSICIAN: ME | DID TOBACCO USE CONTRIBUTE | O CAUSE OF DE | ATH YI | ES X NO C | UNCERTAIL | N 🗆 | | | | | | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | ACE OF DEA | TH (Check only one) | | | | | | | | |
| SIC | EXAMINER? 1 YES 2 NO 1 Input | TAL: ilent 2 - ER/Outpatient | 3 DOA | OTHER: 4 Nursing Hore | e 5 Residence | 6 Other (Sp | ecify) | | | | | |
| ΗY | | DATE OF INJURY | 28b. Til | E OF 28c. IN. | URY AT | | E HOW INJUR | Y OCCURED | | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | IN. | JURY WO | YES 2 NO | | | | | | | |
| ВУ | 3 Suicide 28e. | PLACE OF INJURY - At | home, farm, | atreet, factory, offic | • | | N (Street end No | umber or Rural | Route Number, | | | |
| TED | 4 Homicide datermined | building, atc. (Specify) | | | | City or io | wn, Stele) | | | | | |
| Ш | 290. CERTIFIER 1 CERTIFYING PHYSICIAN: TO IT | a heat of my knowledge | death conum | and at the time date | and place, and due | to the severale | and managed | CONTRACT OF | | | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINER: On the t | | | | | | | | (s) end menner | r es stated. | | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | MBER | 29d | DATE SIGNE | (Month, Day, | Year) | | |
| 0 | Curpe | est ced | Me | hes. | D 1: | 3166 | | 8 | 124/ | 25 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLE | | | s, Print) | | 1 | | | | | | |
| | Angel Roque | EGISTRAR'S SIGNATURE | | Cerrace, | Frasthu | eg, Md. | 21532 |) | | | | |
| | AUG 2 4 1995 Jul | in develope h | really | | | | | | | | | |

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FOR STATE REGISTRAR

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| 1 | MONTH DAY YEAR | | | | | | | | | | | 3. TIME OF DEATH 11:20 DM M | |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------|--------------------|----------------|---------------------------------------------------------|----------------------------|------------------------|-----------------------------------------------------------------------------------|------------------------------|--------------------------------------------|
| | 4. SOCIAL SECURITY NUME | 5. SEX | | | | | | | 7. DATE OF BIRTH | | | PLACE (State or Foreign | |
| ĺ | 139-26-9464 | 1 M 2 GF | □ M 2 💢 F 95 YRS. M | | MONTHS | | | (Month, Day, Year) | | ,, | Country) | | |
| | 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) | | | | | | | | | | | | |
| DIRECTOR | Dennett Rd. Manor Nursing Home Oakland Garrett | | | | | | | | | | | tt | |
| 5 | 10a. STATE | 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN O | R LOCAT | TION | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland | Garre | ett | | Fr | iends | vil | le | | | | | 1 YES 2 NO |
| | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHA | | | | | | | | | | HAT COUNTRY? | | |
| | 935 Second | Avenue | 2 | | | | | 21531 | | | | USA | |
| | 11. MARITAL STATUS 1 Never Married 2 2 Midward 4 Diversity | | 12. WAS DECEDENT FORCES? IF YES, GIVE | YES 2 | NO | H | yes, sp | ENDENT OF HISPAN ecity Cuben, Mexica 2 MD Specify | n, Puerto Rican | | or No— | 14. RACE Black Speci | — American Indian, , White, atc. /y: |
| Ì | 3 Widowed 4 Dive | | | 1 | | | | | | | 1 | | ite |
| | (Specify on | EDENT'S EDUC y highest grade | completed) | | (Give kind of life. Do NOT up | work done d | uring mo | on out of working | 111111111 | 1/11/11/11 | SINESS/IND | | Board of |
| | Elementary/Secondary (| 3-12) | College (1-4 or 5 | | afeter | | velec. | · · | | cati | | IICY | board of |
| | 7 th 17. FATHER'S NAME (First, M | fiddle, Last) | | 10 | arecer | Id WC | JIKE | 16. MOTHER'S NA | | | | | |
| | Jefferson 1 | | milk | | | | | Hanna M | | ., | | | |
| | 19e. INFORMANT'S NAME (| Type/Print) | | | 19b. MAILING | ADDRESS | (Street | and Number or Rural I | Route Number, C | ilty or Tow | m, State, Zip | Code) | 71 -0 |
| | Martin D. | Friend | | | 7213 | O'Dor | niel | Loop, W | , Lake | land | d, FL | 33 | 809 |
| | 20a. METHOD OF DISPOSIT | | LACE AND DATE DF DISPDSITION (Name DATE 26c. LOCATION — City or Town, State setary, crematory or other place) | | | | | | wn, State | | | | |
| | 4 Donation 5 Other | | Oval Holli State | - Blo | oming | Rose | Cen | . Aug 26 | | Fr | ends | vill | e, MD |
| | 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | | | | | ND ADDRESS OF FA | | _ 1 | 2 7 | D 0 | Do 275 |
| | Newman Fund | | | | | | | | | | | | |
| | 23. PART I. Enter the o | Mybases, or o | complications the | at caused th | e death. Do | not antar | the mo | de of dying, suc | h sa cardiec | or resp | iratory an | rest, | Approximate |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. G I Blood 24 A | | | | | | | | | | Interval Between Onset and Death | | |
| DUE TO (OR AS A CONSEDUENCE OF): | | | | | | | | | | 24 NP | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | 1/2 BAKS | |
| | CAUSE (Disease or injust that initiated events resulting in death) LAS | | DUE TO | OR AS A CO | INSEDUENCE D | F): | | | | | | | |
| | | | d | | | | | | | | | | |
| MEDICAL | PERFORMED? 1 □ YES 2 □ NO | | | | | | | | | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| - 11 | | | | | | | | | _ 1 | | | | |
| | 25. WAS CASE REFERRED | TO MEDICAL | | | | | 26. P | LACE OF DEATH (Ch | eck only one) | | | | |
| SICIAIN: | EXAMINER? 1 ☐ YES 2 ☑ ND | | HOSPITAL: | ☐ ER/Outpath | ent 3 🗆 DOA | OTHER 4 I Nun | t: ling Hon | ne 5 🗆 Residence | 6 Other (Sp | ecify) | | | |
| | | Pending | 28e. DATE O (Month, | F INJURY Day, Year) | 28b. TIR | IE OF JURY M | WI | JURY AT DRK? YES 2 NO | 28d. DEŞCRI | BE HOW | INJURY OC | CURED | |
| | 2 Accident 3 Suicide 8 4 Homicide | Could not be datermined | 28e. PLACE building | OF INJURY — I, atc. (Specify) | At home, farm, | street, fact | ory, offic | 20 | 281. LOCATIO City or To | N (Street wn, State | and Number | r or Rund i | Route Number, |
| COMPLE | cond only | | | | | | | and place, and due death occured at the | | | | | a) and manner ee stated. |
| | 29b. SIGNATURE AND TITE | E OF CERTIFIE | BIS | | | | | 29c. LICENSE NU | MBER | | 29d, DA1 | E SIGNED | (Month, Day, Year) |
| | 30, NAME AND ADDRESS D | E DEDOM WA | D COMBI ETER AT | IRE DE SECT | STEM OF C | - Christi | | D26568 | | | 1 | | 1 10 |
| | | | O COMPLETED CA | VOE UF DEATH | T (ITEM 27) (Typ | s, Print) | | | | | | | |
| | Roger Lewi | | Garrett | | | | spid | al, Oak1 | and, N | D | 21550 |) | |
| | AUG 2 | 2 100 | 5 Julia | Bucho | Rodall | 1 | | | | | | | |
| | HUG A | 0 100 | June | | THE PERSON NAMED IN | | | | | | | | DHMH-18 Rev 1/8 |
| | | | | | | | | | | | | | DUMH-19 HeA 1/6 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without without hours after death. Page 6 may be retained by the hospital or attending physician. |
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| be ned whom it a hours after dealt with the State begit, of relating and wernal hyperie prior to burial, cremation, or fembrai. IMPORTANT: If them 28 is marked, or frem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

BEG NO.

| 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 64 7RS. 6. AGE (In yrs. last birthday) 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION August 30, 1995 August 30, 1995 4. SOCIAL SECURITY NUMBER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Morith, Day, Year) 10 DATE OF BIRTH (Morith, Day, Year) 9b. CITY, TOWN OR LOCATION 10c. CITY, TOWN OR LOCATION | 3. TIME OF DEATH 10:44 A M | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--|--|
| 4. SOCIAL SECURITY NUMBER 20-38-2011 1 M 2 F 64 YRS. 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BRITH (Morth, Day, Year) JAN. 27, 1931 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital AESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | 10. TT M | | |
| 220-38-2011 1 M 2 F 64 YRS. MONTHS DAY'S HOURE MHN. (Morth, Day, Year) JAN. 27, 1931 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital ABSIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | I. BIRTHPLACE (State or Foreign | | |
| 96. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital RESIDENCE OF DECEDENT 106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCCUPATION OCC | Country) MARYLAND | | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | Y OF DEATH | | |
| 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | es | | |
| MADVI AND CHADIES NAMED OF | 10d, INSIDE CITY | | |
| | LIMITS? | | |
| 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZE | EN OF WHAT COUNTRY? | | |
| | ED STATES | | |
| | 4. RACE — American Indian, Black, White, etc. | | |
| 3 Wildowed 4 Divorced 1 YES, GIVE WAR OR DATES 1 YES 2 THO Specify: | Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE 17. FATHER'S NAME (First, Middle, Last) CANUALTY CONTROL OF SUSINESS/INDUS 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| Elementery/Secondary (0-12) College (1-4 or 5+) II/O/A/TE MAIZED | | | |
| 12TH GRADE HOME MAKER PRIVATE 17. FATHER'S NAME (First, Middle, Maiden Surname) | | | |
| | | | |
| SAPUBL GUIRICK 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co. | | | |
| WILLIAM A. POSEY, SR. #8920 JACKSONTOWN ROAD, NANJEMOY, MAR | YLAND 20662 | | |
| 1 AJ Sunai 2 U Cremation 3 U Hernoval from State cametery crematory or other place | CATION — City or Town, State | | |
| 21. MONAGE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY | , MARYLAND | | |
| THORNTON FUNERAL HOME, P.A. | | | |
| LIDIA C. THORNTON JOHNSON M00583 #3439 LIVINGSTON ROAD, POMONKI 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres | EY, MARYLAND | | |
| anock, or heart tailure. List only one cause on each line. | Interval Between | | |
| IMMEDIATE CAUSE (Final disease or condition a CA MCER DE BREAST | Onset and Death | | |
| DUE TO JOB AS A COMPANIANCE | 0.4 | | |
| Sequentially list conditions, | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): | | | |
| d | | | |
| | 24b. WERE AUTOPSY FINDINGS | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. | AVAILABLE PRIOR TO | | |
| PART II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? | COMPLETION OF CAUSE | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Performed? 1 YES 2 NO | | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | COMPLETION OF CAUSE OF DEATH? | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | COMPLETION OF CAUSE OF DEATH? | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) EXAMINER? 1 Inpatient 2 ER/Outpetiant 3 DOA 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCUPY | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER: 1 OTHER: 1 OTHER: 1 NOWING NOTHER: 1 NOWING OF DEATH 28s. DRAFT OF INJURY (Month, Day, Year) 28s. DRAFT II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OTHER: 1 NOWING OF DEATH 28s. DRAFT II. Other (Specify) 28s. DRAFT II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25s. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 NOWING OF DEATH 26s. PLACE OF DEATH (Check only one) 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER OF DEATH 27s. MANNER | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
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| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Maildence 8 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 DOA DOA Nursing Home 5 Maildence 8 Other (Specify) 26a. DATE OF INJURY 26b. TIME OF INJURY AT WORK? 1 YES 2 NO UNCERTAIN 27. MANNER OF DEATH 28a. DATE OF INJURY — At home, Iarm, strast, Isotory, office 28d. DESCRIBE HOW INJURY OCCUPATION, Day, Year) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28a. PLACE OF INJURY — At home, Iarm, strast, Isotory, office 28l. LOCATION (Street and Number or City or Town, State) 28b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. DATE S 29d. | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(s) and manner as stated. | | |
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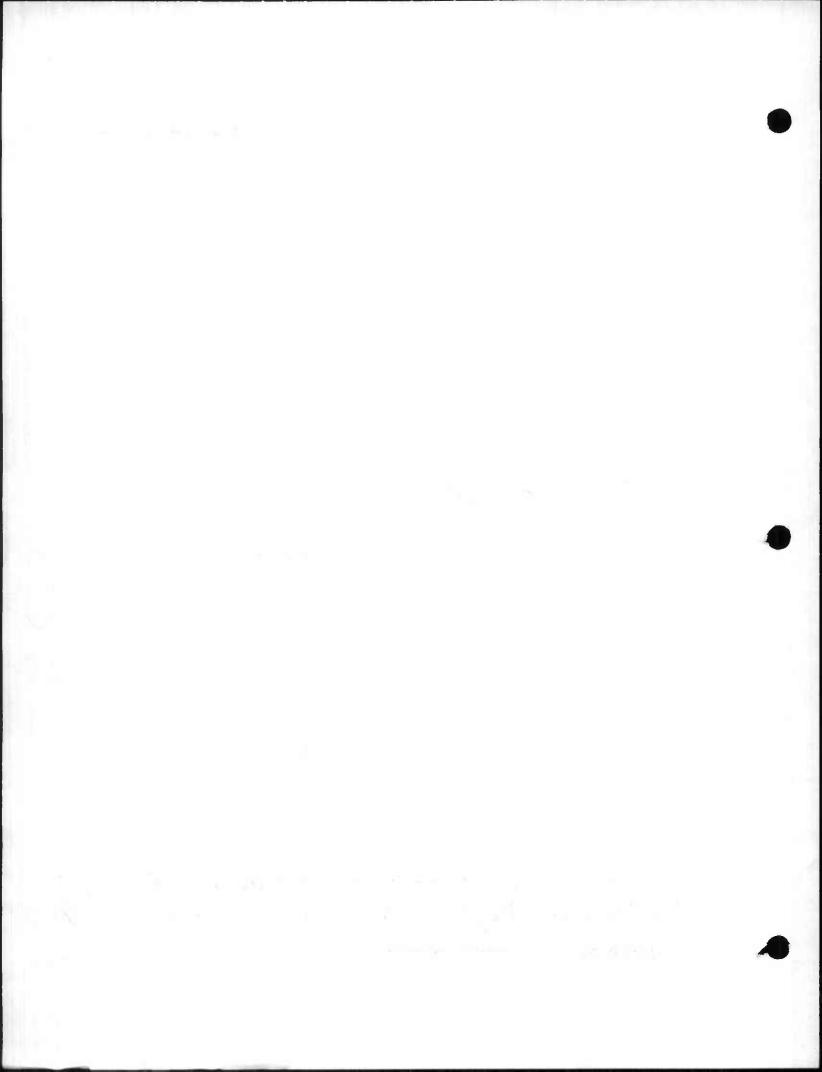
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | HEGISTIAN | | | SHIIF | CALE | UF | DEA | ın . | R | IEG. NO. | | | | |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------|----------------------------|--------------|----------------------|---------------|-------------|----------------------------------|---------------|-------------------------------------------|-------------------|--------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | | | 2. DATE OF | DEATH | W 4 . | YEAR | 3. TIME OF DEATH AND A | |
| | | ison, Jr. | | | | | | | FTU | 6- i | 4 19 | 95 | EST 12" | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 1 N 2 F | 6. AGE (In yrs. les | t birthday) | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTH | | IPLACE (State or Foreign | |
| | 217-42-9135 | YRS. | MORTHS | DAYS | HOURS | MIN, | April | 29, | 1944 | 1944 Maryland | | | | |
| _ | 9a. FACILITY NAME (If not institution, give st | treet and number) | | | 9b. CITY, | TOWN (| OR LOCATI | ON OF DE | ATH | - | 9c. COUN | ITY OF D | EATN | |
| e l | 5 Park Ave. | | | | Ridg | gely | 7 | | | | (| Caro | line | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | , | | I a a | | | | | | | | | | |
| DIRECTOR | | | | | r, TOWN O | | TION | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Caro | line | | | Ridge | - | | | | | | 1X YES 2 NO | | |
| FUNERAL | 5 Park Ave. | | | | | 101 | . ZIP COD | | | | WHAT COUNTRY? | | | |
| ¥ | 11. MARITAL STATUS | | | | | | 216 | | | | | S.A. | | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT FORCES? 1 | | NO NO | | | | | NC ORIOIN? (S n, Puerto Ricar | | or No- | 14, RACE Black | E American Indian, c, White, atc. | |
| A | 3 Widowed 4 Divorced | IF YES, OIVE W | AR OR DATES | | 1 | YES | 2 🔯 NO | Specify | | | | Speci | White | |
| | 15. DECEDENT'S EDUC | | 16a, DE | CEDENT'S | USUAL OC | CUPATIO | ON | | 16b. KIN | D OF BUS | INESS/IND | USTRY | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 + | (G | ive kind of w Do NOT us | vork done a | luring mo | st of working | ng | 1000 1000 | 0, 500 | MVL00/MVD | 001711 | | |
| 립 | 12 | 0011090 (1-4 01 3 4 | | uto | body | rep | air | | car | dea | lers | hip | | |
| O | 17. FATHER'S NAME (First, Middle, Lest) | | | | | | | HER'S NAI | ME (First, Middl | e. Maiden | Sumame) | | | |
| | James O. Robison | , Sr. | | | | | | | V. Jo | | | biso | n | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 190 | b. MAILINO | ADDRESS | (Street a | and Number | or Rural R | loute Number, C | City or Town | , Statu, Zio | Code) | | |
| 임 | Tammy Lynn Robis | on | | | | | | | , Mary | | | 660 | | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | AND DATE O | FDISPOSI | TION /Na | ame of | | OATE | _ | CATION — (| City or To | wn. State | |
| | 1 Surial 2 ☐ Cremation 3 ☐ Ramo 4 ☐ Donation 5 ☐ Other (Specify) | oval from State | Gree | metory or of | ro C | emet | erv | | 8/18 | | | | , Maryland | |
| | 21. SIGNATURE OF UNERAL SERVICE LIC | ENSEE | , | | | | O ADDRE | SS OF FAC | | | | | , | |
| | > Mule | Fle | yla | _ | F. | leeg | gle-H Box | lelfe | nbein | | ral l | Home MD | 21639 | |
| | 23. PART i. Enter the diseases, or c | omplications that | caused the de | ath. Do n | | | | | aa cardiac | or respli | ratory arre | est, | Approximate | |
| | shock, or haert failure. I IMMEDIATE CAUSE (Final |). | | | | | | | | | Interval Between Onset and Death | | | |
| | | CARD | 10-00 | 1- M | 1110 | -01 | / 4 | -00 | 656 | | | | | |
| | readiting in death) | DUE TO | OR AS A CONSEC | DUENCE OF |): | 1 | <i>p</i> | 7210 | 271 | | | | 1,000 | |
| z | disease or condition resulting in death) a. CARDIO-PULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): CHRONIC INANITION AND CATABOLISM CHYONK DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| 일 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | L | | | | | | | | | | C. | O PATION | |
| | that initiated events resulting in death) LAST | DUE TO (| OR AS A CONSEC | DUENCE OF |): | | | | | | | | | |
| ER | readiting in death) EAST | ı | | | | | | | | | | | | |
| | PART il. Other aignificant conditions | a contributing to | deeth but not r | eaulting i | n the unc | derivino | Cause o | niven In I | Pert i 24s | . WAS AN | AITTOPRY | 245 | WERE AUTOPSY FINDINGS | |
| EDICAL | | 111111111111111111111111111111111111111 | and the citation, my cause given in a | | | | | PERFORMED? | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | | | | | | | | | _ 10 | YES 2 | NO | | OF DEATH? | |
| Σ | - | | | | | | | | _ | | | | 1 TES 2 NO | |
| A N | 25. WAS CASE REFERRED TO MEDICAL | | | | | 00.00 | | | | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | - | OTHER | : | | | ick only one) | | | | | |
| <u>"</u> | 27. MANNER OF DEATH | 1 □ Inpatient 2 □ | | 28b. TIME | | ing Hom- 28c. INJ | | aldenca | 6 Other (Sp | | | | | |
| | 1 Natural 5 Pending | (Month, Da | y, Year) | INJ | JRY | | RK? | 7 100 | 28d. DESCRIE | SE NOW IN | JURY OCC | URED | | |
| À | Accident Investigation 3 Suicide 6 Could not be | 28a PLACE OF | INJURY — At ho | | | | | NO | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | building, a | ntc. (Specify) | irre, reitrii, s | treet, tecto | ry, orner | | | City or To | wn, State) | nd Number | or Rural R | loute Number, | |
| W | 29a, CERTIFIER | | | | | _ | | | | | | | | |
| 를 | (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of r | | | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINER | : On the basis of ax | emination and/or i | nvestigation | n, In my op | olnion, de | eath occur | ed at the t | time, data and | place, and | due to the | cause(a) | and menner as stated. | |
| | 296 SIGNATURE AND TITLE OF CERTIFIER | mo | Donit | 11 1 | 15 | 7 | 29c LICE | NSE NUM | BER | 1 | 29d, DATE | SIONED | (Month, Day, Year) | |
| 0 | Offenden | 1110-3 | Sugna | 4 / | 111 | * * | D | 14 | 664 | - | 18 | 1 | 7-95 | |
| - | 30 NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITE | 12 (Type) | Print) | an | 1 | (NI | 711 | 1 1 | 10 | 7 | (20 | |
| | C.L. JENJEI | VIII | , TOU | DUI | 16 | 70 | IP | EN | rcon | I N | ID. | 1 | 627 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAF | · . | | | | | | | | | | | |
| | AUG 1 8 '95 | guna d | airdson-R | indell | | | | | | | | | | |



Pages 1, 2, 3 should

| leath certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per | ntal Hygiene prior to burial, cremation, or removal. | ry, or other traumatic event, the medical examiner must be notified at once. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hous after death. Page 6 may be retained by the hospital or attend | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

2

AND ADDRESS OF PERSON

8

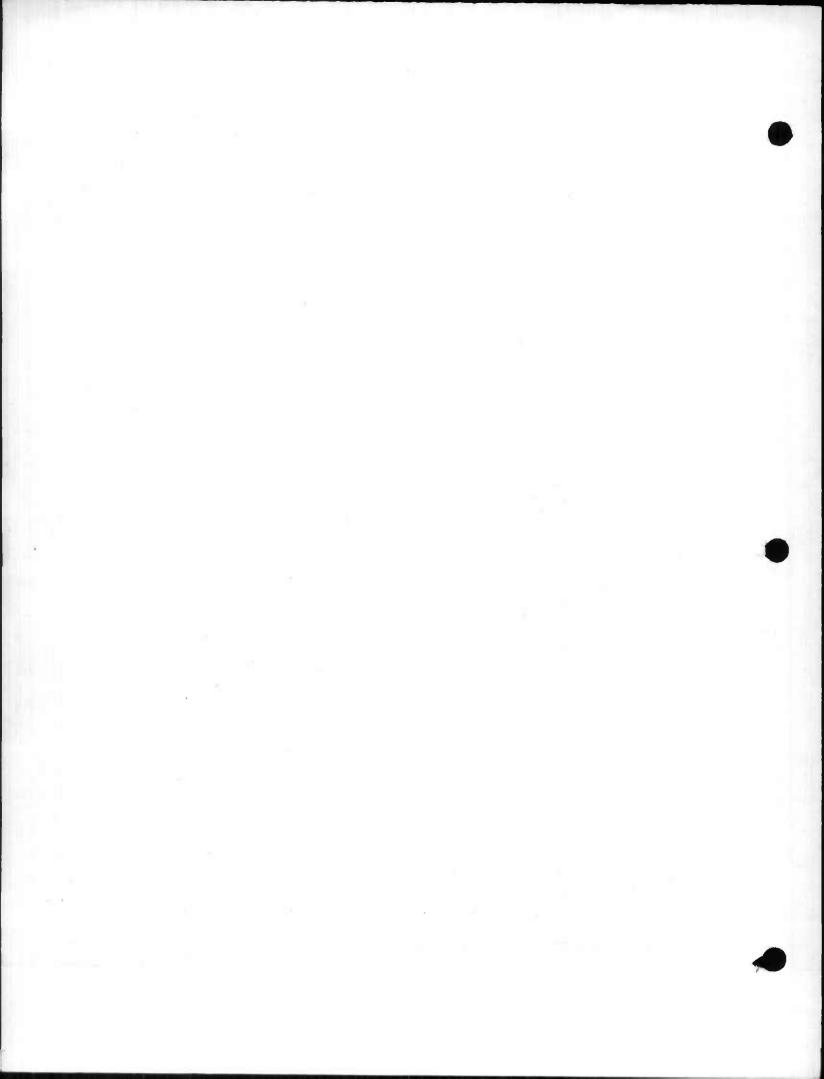
31. DATE FILED (Month, Day, Year)

95 27475 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) STEVEN ROCHE DENNIS 995 4:00 PM AUGUST 3 6. AGE (In yrs, last birthday) 7. DATE OF BIRTH (Month, Day, Yea 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 MRS. DAVE HOURS BARN 1 🔯 M 2 🗌 F Jan 9, Maryland 217-02-4528 16 1979 9a. FACILITY NAME (If not institution, give as 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH ANNE ARUNDEL Lothian 162 #B UPPER CREEK DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Calvert Huntingtown 1 - YES 2 X NO 10a. STREET AND NUMBER 101. ZIP CODE FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 2605 Kings Landing Road 20639 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, stc. FORCES? 1 YES 2 1 Never Married 2 Married Specify: BY 3 Widowed 4 Divorced white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15 DECEDENT'S EDUCATION 16b KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) student high school 18. MOTHER'S NAME (First, Middle, Malden Surname) 17. FATHER'S NAME (First, Middle, Last) Amanda Michele Greenwell Gary Joseph Roche BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zin Code) same as # 10 above Amanda M. Roche 20e. METHOD OF DISPOSITION
1 □ Burlel 2X Cremation 3 □ Ramoval from State
4 □ Donation 6 □ Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Metropolitan Crematory 8/17/95 Alexandria, VA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Willian Rausch Funeral Home, P.A., Owings, MD 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory streat, shock, or heart feiture. List only one cause on each line. Approximate Onset and Death IMMEDIATE CAUSE (Finsi disease or condition Positional asphyxia complicating acute alcohol resulting in death) DUE TO (OR AS A CONSEQUENCE OF): intoxication CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL YES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER:
4 | Nursing Home 5 | XRaaidence HOSPITAL: TX YES 2 NO tlent 2 - ER/Outpetient 3 - DOA 28d. OESCRIBE HOW INJURY OCCURSO SUBJECT CONSUMED EXCESSIVE alcohol & 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT (Month, Day, Ye 8-13-95 1 Netural 1 YES 2 XNO Unk was trussed. BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 6 2 D CL 3 Sulcide 6 Could not be determined ETED Creek Mobile Estates Lyons Yard 4 X Homicide 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know COMPL 29d. DATE SIGNED (Month, Day, Year) ATURE AND TITLE OF CERTIF O.C.M.E BE ▶ AUGUST 14,1995

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

32 REGISTRAR'S SIGNATURE Davidson-Randall

DHMH-16 Rev 1/89



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 124 hours after death. Page 6 may be retained by the hospital or attending physician. | UNRECTOR. After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | z nous arec cean wint he state bett, or ream and wenta hypere pror to butta, dematch, or remova. I them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING | TO THE FUNERAL DIRECTOR: After this certif | IMPORTANT: If Item 28 is marked, or |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTING | | | MENTAL | L HYGIEN | E | | |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------|---------------------------------------------------------|-----------------------------------------------|------------------------------------|-----------------------------------------------------------------------|----------|--------------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | | | 3. TIME OF DEATH |
| | Ethel | | | ALIC | | | EAR 5 | 0850 M | | |
| | | SEX 6. AGE (In y | rs. last birthday) | LIGGS FUNDER 1 YEAR | IF UNDER 24 HRS. | 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State | | | | LACE (State or Foreign |
| | 219-36-8129 1 9a. FACILITY NAME (If not institution, give street | $219-36-8129$ $1 \square \text{ M } 2\mathbb{X} \text{ F}$ 57 Yrs. Months DAYS HOURS MIN. March $31,1938$ Mary | | | | | | | yland | |
| Œ | Calvert Memorial H | | - " | | | | | 9c. COUNT | | |
| 5 | RESIDENCE OF DECEDENT | tospital | | rrince | Frederi | .ck | | Cal | ver | t |
| DIRECTOR | Maryland 106. COUNTY Calv | vert | 10c. CITY, T | Prince | Frederi | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2XXNO |
| AL | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | | 10g. CITIZE | | IAT COUNTRY? |
| EB | 50 Central Villa | ige Drive | | | 20678 | | | US | A | |
| BY FUNERAL | 11. MARITAL STATUS 1 | 2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | ZNO | If yes, sp | ENDENT OF HISPA city Cuban, Mexico 2 XXNO Special | en, Puerto R | | Yea or No- 14. RACE - American Indian, | | |
| G | 15. DECEDENT'S EDUCAT | ION 16 | a. DECEDENT'S US | UAL OCCUPATION | ON . | 16b. | KIND OF BUS | INFSS/INDI IS | TRY | |
| E | (Specify only highest grade con Elementary/Secondary (0-12) | mpleted) College (1-4 or 5+) | (Give kind of work life. Do NOT use re | done during mo | st of working | 1 | | | | |
| 45 | 12 | Johnson (1-4 of o 4) | Housew | ife | | | Own | Home | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | AME (First, A | fiddle, Maiden | Surname) | | |
| BE | Charles Calv | vin Jon | es | | Laura | | Beatr: | ice | 1 | Harvey |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | nd Number or Flurei | | | | | |
| ۲ | Jacqueline Riggs Br | own | 50 Cent | ral Dr | ive Pri | nce F | reder | ick, M | D 2 | 0678 |
| | 20e, METHOD OF DISPOSITION 1 Ø Burtel 2 Cremetion 3 Remove 4 Donation 6 Other (Specify) | I from State 20b, PL. | ACE AND DATE OF C y crematory or other Veterans | Cemet | erv 8/ | 28/95 | Che | eltenh | am. | MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | SEE | | 22. NAME AF | D ADDRESS OF FA | CILITY SO | wa11 1 | Tunoro | 1 U. | 0m0 |
| | * Xbourga | 5 8000 | -000 | 1451 1 | laras Ra | ach R | d Dr | inco E | rode | erick, MD |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Melastetic Endemeth of Carcingne Dicyrosed | | | | | | | | | Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PERFORMEO? | | | | | | | WERE AUTOPSY FINDINGS WARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| 2 | DID TOBACCO USE CONTRIB | SUTE TO CAUSE OF I | DEATH YES | □ NO □ | UNCERTAI | | | | ' | YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | PLACE OF DEATH | | OTTOLKIAI | - U | | | | |
| SIC | EXAMINER? | OSPITAL: X inpetient 2 D ER/Outpetie | mt 3 DOA 4 | THER: | 5 🗆 Rasidenca | B □ Debas | (Specific) | | | |
| ¥ | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 26b. TIME O | F 28c. INJ | JRY AT | | CRIBE HOW IN | JURY OCCUP | RED | |
| ВУР | 1 Natural 5 Pending 2 Accident investigation | (Month, Day, Year) | INJUR | M 1 U | RK? ES 2 NO | | | | | |
| | 3 Suicide 6 Could not be determined | 26a. PLACE OF INJURY — building, atc. (Specify) | Al home, farm, stree | et, factory, office | | 28f. LOCA City o | ATION (Street a or Town, State) | nd Number or | Rurei Ro | ute Number, |
| COMPLETED | | N: To the best of my knowledg On the basis of examination an | | | | | | | ause(s) | and manner as stated. |
| | | | | | | | | Month, Day, Year) | | |
| TO BE | (hunter | | | | 2386 | 91 | | D A | Yeust | -25.1995 |
| F | 30. NAME AND ADDRESS OF PERSON WHO CO WALLANDEL DIPAE 31. DATE FILEO (Month, Day, Year) ALIG 2.8. 1995 | OMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Pri | ne) 40 | PRINCE F | REDE | واديد | an. | | ↓ 18 |
| | 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGNATU | 25 111 | · · · · · · · · · · · · · · · · · · · | · | | | | | |
| | AUG 2.8. 1995 | Stolen Bandan | larball | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Preceduled by the hospital or attending physician.

TO THE FUNEDAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in the time of account of the state of the size of the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or anneal account of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | | | 9 |) | 61411 |
|---------------------------------------------------|-------------------------------------|-------------------------------------|----------------------------|----------------------------------------------------|------------|--------------|--------------------|------------|------------------|----------------------|----------------|------------|-----------------------------------------------|
| FOR | | STATE OF I | /ARYLAN | D / DEPAR | TMEN | T OF H | FAITH | AND I | MENTA | I HYGIEI | VE. | | |
| 1 - STATE REGISTRAR | | | | CERTIF | ICAT | E OF | DEAT | H | WEIGH. | REG. NO | | | |
| 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | _ | | 2. DAT | E OF OEATH | DAY | YEAR | 3. TIME OF DEATH |
| | AL | L. | RIZ | | | | | | AUG | | 6 | 1995 | 10:55 A M |
| 4. SOCIAL SECURITY NUM | | 5. SEX | | s. lest birthday) | IF UNDE | DAYS | IF UNDER : | MIN. | 7. DATE | OF BIRTH | | | HPLACE (State or Foreign |
| 175-28-8672 | | 1 🗆 M 2 💢 F | | 88 YRS. | wowing | LIATE | HOURS | merre, | Aug | ust I | 3 190 | Ma | ryland |
| 9a. FACILITY NAME (If not in | - | , | | | 9b. CIT | Y, TOWN C | R LOCATIO | N OF DE | ATH | | 9c, COL | INTY OF | DEATH |
| MEMORIAL HOS | PITAL 8 | MEDICA | L CENT | CER | CUM | BERLA | AND | | | | ALI | LEGAN | VY |
| 10a. STATE | 10b. COUNTY | | | 10c, CIT | Y. TOWN | OR LOCAT | ION | _ | | | | | 10d. INSIDE CITY |
| Maryland | Garre | t.t. | | В | Toon | ningt | on | | | | | | LIMITS? |
| 10a. STREET AND NUMBER | | | | ~ | | | ZIP COOE | | | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| Box 88 | | | | | | 1155 | 21523 | 3 | | | | | States |
| 11. MARITAL STATUS | | 12. WAS OECEOEN | T EVER IN U.S | . ARMED | 13 | | | | IIC ORIGI | N? (Specify Y | | 14. RAC | E — American Indian. |
| 1 Never Married 2 | | FORCES? 1 | | | | It yes, spe | 2 X NO | , Mexica | n, Puerto | Rican, etc.) | | Spec | k, White, etc. |
| 3 ☑ Widowed 4 □ Divo | Proed | | | | | | N | | | | | | White |
| (Specify only | EOENT'S EOUCA y highest grade co | TION ompleted) | 164 | Give kind of v (Give kind of v Me. Do NOT us | USUAL O | during mos | N st of working | | 16 | b. KIND OF BU | ISINESS/IN | DUSTRY | |
| Elementary/Secondary (0 |)-12) | College (1-4 or 5 | ·) | Homen | | | | | | Hom | 0 | | |
| Unknown 17. FATHER'S NAME (First, M | lielelle (eas) | | | Homein | axei | - | | | | | | | |
| Jacob L | | | | | | | | | | Middle, Melde | Surname) | | |
| 19a. INFORMANT'S NAME (1 | | | | 405 404 1140 | 100000 | | | | asor | | | | |
| Ruth St | | | | | | | | | | nber, City or To | vn, State, Zij | p Code) | |
| 204 METHOD OF DISPOSIT | | - | 200 014 | DU. | | | oomir | igto | | | 523 | | |
| 1 ABurtal 2 □ Cremetto 4 □ Donetion 5 □ Other | n 3 🗆 Remove | wi from State | cemetery | est law | ther place |) | meor | | OAT | 7E 20c. L | OCATION — | City or To | own, State |
| 21. SIGNATURE OF FUNERA | 1.4 | WSEE | 10° | CSLIAW | 22 | NAME AN | D ADDRESS | S OF FAC | ns c | -119-9 |) <u>Га</u> . | Vale | . Ma |
| · 7/1 | 11 | 201 | / | | | Boal | Fune | ral | Hon | | | | |
| W | my, | W X |) 049 | | | 111 | Churc | h S | t. K | esteri | port | . Ma | 21562 |
| 23. PART i. Enter the di shock, or h | eart fallure. Lis | mplicetions that st only one ceu | t coused the se on each | line. | ot ente | r the mo | de of dyln | g, such | aa car | diec or reap | eiratory ar | reat, | Approximate Interval Between |
| IMMEDIATE CAUSE (Fir disease or condition | nai | CARCT | MOMAN MO | 0.7.0 | | | | | | | | | Onset and Death |
| resulting in death) | → a. | | NOMATO | | | | | | | | | | MORE THAN |
| | | | | NSEOUENCE OF | | | | | | | | | |
| Sequentially list conditi | | | | O COLO | | ANCER | | | | | | | 2 and 1/2 |
| If any, leading to immed cause. Enter UNDERLYI | | | | | | מאים מכ | MEM | A CM A | OFC | | | | years ago |
| CAUSE (Disease or Inju | ry C. | | | AND WI | | READ | META | ASTA | SES | | | | |
| resulting in death) LAS | T I | | | | | | | | | | | | İ |
| | 0. | | | | | | | | | | - | | |
| PART II. Other significa | nt conditione | contributing to | death but n | ot resulting i | n the u | nderlying | cause gl | ven in I | Part I. | 24a. WAS AI PERFO | | 24b | . WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| | | | | | | | | | | 1 TYES | NO NO | | COMPLETION OF CAUSE OF OEATH? |
| | | | | | | | | | _ | | / V | | 1 TES 2 NO |
| DID TOBACCO U | | BUTE TO CA | | | | NO 🗆 | UNCE | RTAIN | 1X | | | | _ |
| 25. WAS CASE REFERRED TO EXAMINER? | | OSPITAL: | 26. P | LACE OF OEAT | H (Check | | | | | | | | |
| 1 TYES 2 NO | f | Inpatient 2 | | t 3 🗆 DOA | | | 5 🗆 Resi | Idence I | B 🗆 Othe | er (Specify) | | | |
| 27. MANNER OF OEATH | Pending | 80. OATE OF (Month, De | | 28b. TIME | | 28c. INJU | RK? | Ì | 28d, OE | SCRIBE HOW | INJURY OC | CUREO | |
| 2 Accident | investigation | 44 - 81 405 0 | F 10.1 11.100.1 | | М | 1 🗆 Y | | NO | | | | | |
| | Could not be determined | building, | etc. (Specify) | t home, tarm, a | treet, fac | tory, office | | | 281. LOC City | or Town, Stete | and Number | or Rural F | Route Number, |
| AND CERTIFIED AA | 15.6.490.49 | | | | | | | | | | | | |
| (Check only | | N: To the best of | | | | | | | | | | | |
| | AL EXAMINER: | On the basis of as | amination and | l/or investigation | n, In my | opinion, de | ath occured | d at the t | ilme, date | and plece, e | nd due to th | te cause(e | e) end menner as stated. |
| 29b. SIGNATURE AND THE | OF CENTIFIER | | | 1 6 | | | 29c. LICEN | SE NUM | BER | | 29d. DAT | E SIGNEO | (Mgoth Day, Year) |
| | yelle | me | 1 | 4 9 | 7 | N | D 16 | 041 | | | ►AU | GUST | 24/195 |

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CUMBERLAND,

AVENUE,

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DR.

TERRY WILLIAMS

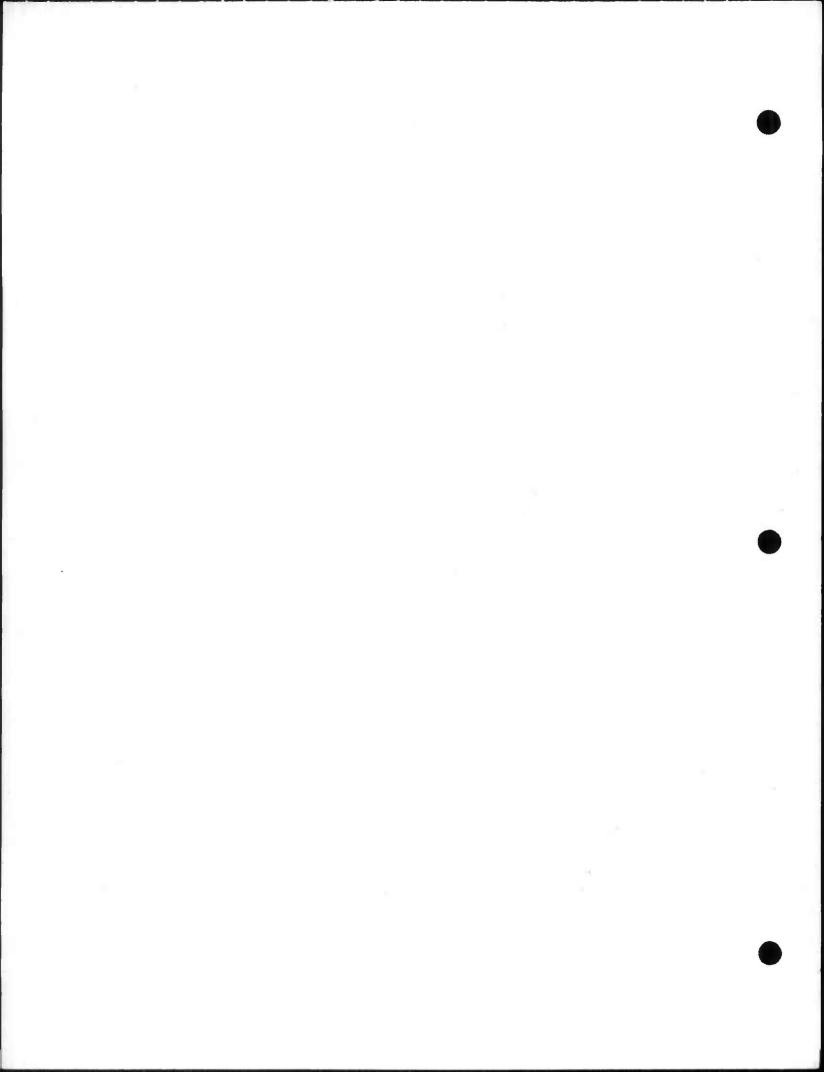
31. OATE FILEO (Month, Day, Year)

AUG 2 2 1995

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12. Aggistrag of SIGNATURE Sold Al

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

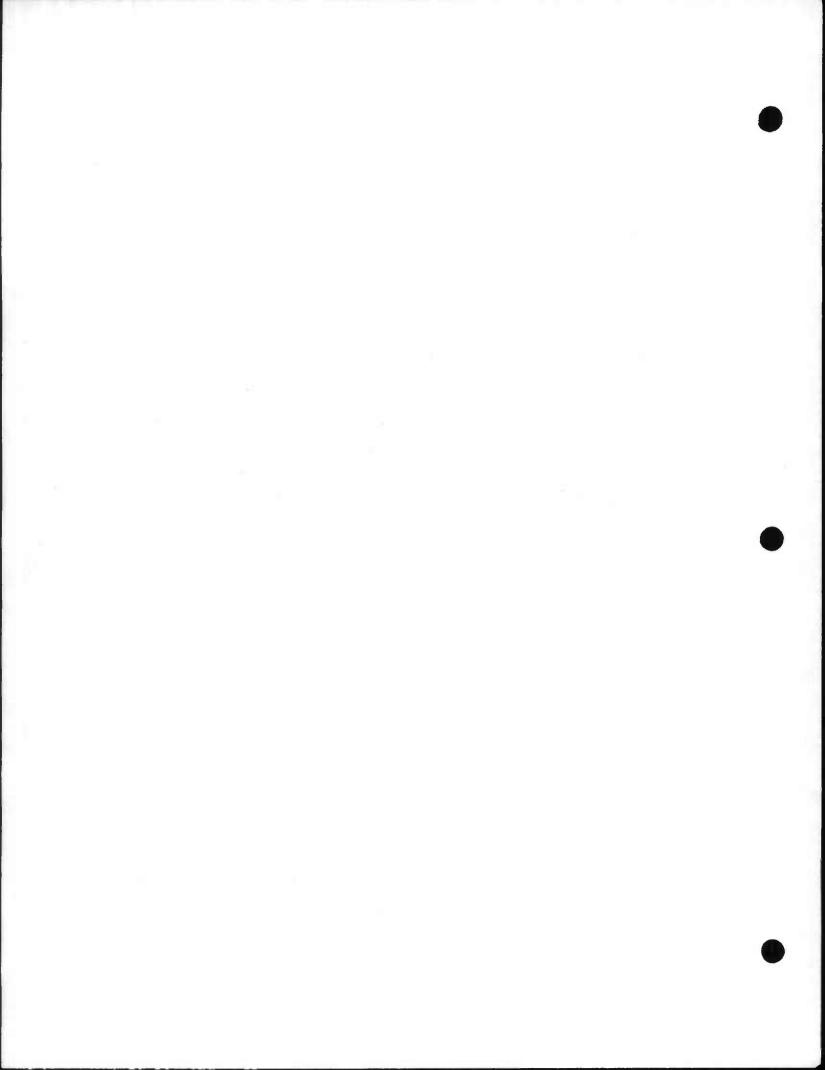


ttending physician. e as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| | TO THE HUSPITAL OH ALLENDING PHYSICIAN. THE LAW FEQUITES That the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or at | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | ĺ |
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| | 1 - STATE REGISTRAR | STATE OF MARY | | NT OF HEALTH AN | D MENTA | AL HYGIEN | E | | | | |
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| | MARVIN HAROLD RIGGLEMAN AUGUST 12 1995 0 | | | | | | | | 3. TIME OF DEATH | м | |
| | 4. SOCIAL SECURITY NUMBER 233-50-3658 90. FACILITY NAME (If not institution, gi | 5. SEX 1 M 2 F No street end number) | 929 | e. BIRTHP Country) W . V | LACE (State or Foreign | gn | | | | | |
| TOR | Sacred Heart Ho | pspital | Allegany | | | | | | | | |
| DIRECTOR | W. Va. Mine | | | | 10d. INSIDE CITY LIMITS? | , | | | | | |
| FUNERAL | P. O. Box 284 | | | 101. ZIP CODE 26750 | | | | S.A. | IAT COUNTRY? | | |
| 8 | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | PANIC ORIGI xicen, Puerto ecily: | IN? (Specify Yee Rican, etc.) | | 14. RACE Black, | - American Indian, White, etc. | | | | |
| COMPLETED | 15. DECEDENT'S (Specify only highest gi | EDUCATION rade completed) College (1-4 or 5+) | Ille. Do NOT use retire | one during most of working | 16 | b. KIND OF BUS | | ISTRY | | | |
| OME | 17. FATNER'S NAME (First, Middle, Last) | | Driver | 18. MOTNER'S | NAME (First, | Truck | | ompa | ny | - | |
| BE C | Jacob P. Simmor | 18 | | | | Rigglem | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Dorothy L. Brai | ithroite | | ESS (Street end Number or Ru | | | | 2675 | 0 | | |
| | 20a. METHOD OF DISPOSITION | 20 | 06. PLACE AND DATE OF DIS | | | TE 20c. LO | | | | - | |
| | Commetery, Cremetory or other place) Commetery, Cremetory or other place) Ebenezer Cemetery 8-15-95 Romney, W. Va. | | | | | | | | | | |
| | 1 Xx. A | Die | | Miller Funer P. O. Drawer | ral Ho | Romn | ev. W | . Va | . 26757 | | |
| CERTIFICATION | 23. PART Friedric diseases, or conditions that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) INTERP CRIMIN U MEMORIAS 368 Due to (or as a conseduence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) CAUSE (Disease or Injury) | | | | | | | | | | |
| MEDICAL | PERFORMED? 1 YES 2 NO CO | | | | | | | | VERE AUTOPSY FINDS WAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? YES 2 NO | 100 | |
| PHYSICIAN: | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (Ch | | AIN 💢 | | | | | | |
| YSIC | 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Ou | tpatient 3 DOA 4 D | IER: Nursing Home 5 ☐ Residen | ce 6 🗆 Oth | er (Specify) | | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | | 28c. INJURY AT WORK? | 28d. DE | SCRIBE NOW IN | JURY OCCU | RED | | | |
| TED BY | 3 Suicide 8 Could not | 2 Accident Investigation 3 Suicide 8 Could not ba 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, Specify) | | | | | | | | | |
| COMPLETED | | IYSICIAN: To the best of my kno- IINER: On the basic of examinati | | | | | | | end menner ee state | d. | |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIF | FIER | | 29c. LICENSE | NUMBER | | 29d, DATE | SIGNED (A | Honth, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON | WNO COMPLETED CAUSE OF A | EATH (ITEM 27) (Kinsa Print) | D2893 | 12 | | A | UGUS | T 16-9: | 5 | |
| | MOHAMMAD SHAF | IEI, M.D. 91 | 5 SETON DRIV | VE CUMBERLAN | D, MD | 21502 | 2 | | | | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYL | LAND / DEPARTING | MENT OF HEA | ALTH AND I | MENTAL HYGIEN | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| 1 | CLYDE | EMORY | ROBERTSON | | | AUGUST 14 | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. lest birthday) | a, Biff | TNPLACE (State or Foreign | | | | |
| | 217101390 9a. FACILITY NAME (If not institution, give s | 390 1 M 2 □ F 76 VRS. MONTHS DAYS HOURS MIN. JUNE 4 1919 Country) | | | | | | | |
| DIRECTOR | MEMORIAL HOSPITAL | | | UMBERLAN | | ATH | 9c. COUNTY OF ALLEG | | |
| DE L | 10a. STATE 10b. COUNTY | Y | 10c. CITY, T | OWN OR LOCATION | 1 | | | 10d. INSIDE CITY | |
| | | LEGANY | CU | MBERLAND | | | | LIMITS? | |
| FUNERAL | 100. STREET AND NUMBER | | | 10f, ZI | P CODE | | | WHAT COUNTRY? | |
| N. | 301 REYNOLDS STRE | | | | 21502 | | U.S | .A. | |
| BY | 1 Martial Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 M YES IF YES GIVE WAR OR O U.S. ARMY WW | IN U.S. ARMED 2 NO PATES | It yes, specif | DENT OF NISPAN y Cuban, Mexicar NO Specify | IC ORIGIN? (Specify Yea n, Puerto Ricen, etc.) | Bla | CE — American Indian, ick, White, atc. | |
| 8 | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a. DECEDENT'S US | UAL OCCUPATION | | 16b. KIND OF BUS | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use re | done during most o tired.) | f working | | | | |
| MP | 12 | | CLERK-U.S | . POSTAL | SERVICE | POST | OFFICE | DEPT. | |
| 8 | 17. FATNER'S NAME (First, Middle, Last) | | | -10 | MOTHER'S NAI | ME (First, Middle, Maiden | Surname) | | |
| BE | EMORY ROBERTSON | | | | IDA TH | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | loute Number, City or Town | | | |
| | MABEL M. ROBERTSO | | 301 REY | NOLDS ST | REET CU | MBERLAND N | 1ARYLAND | 21502 | |
| | 20a_METHOD OF DISPOSITION 1. Burtel 2 Cremetion 3 Rame 4 Donation 5 Other (Specify) | oval from State ST | DASET CEME | | GUST 16 | | BERLAND | Town, Stata MARYLAND | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | MHREE | | 22. NAME AND A | DDRESS OF FAC | FUNERAL HO | ME | | |
| | Dale Zi | lesnith | | | | REET CUMBI | | ARYLAND | |
| | 23. PART I. Enter the diseases, or o | complications that cause | d the death. Do not | | | | | Approximate | |
| | IMMEDIATE CAUSE (Final | List Dniy Dne cause Dn e | eech line. | | | | | interval Between Onset and Death | |
| | | INTRAOPERATIVE BLOOD LOSS- DUE TO EXTENSIVE KIDNEY CANCER 3 HR | | | | | | | |
| | rounting in addition | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| Z | Sequentially list conditions, if any, leading to immediate 50 YEARS OF SMOKING DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
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| 일 | | EXTENSIVE I | XTENSIVE LEFT RENAL CANCER WITH METASTASIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| CERTIFICATION | that initiated eventa reaulting in death) LAST | d CHRONIC OBS | | PULMONAR | Y DISE | Sol him | Aug 14 | , 1995 50 YRS | |
| 1 8 | PART ii. Other significant conditions | s contributing to deeth t | out not resulting in t | he underlying or | una chuan la l | Part I. 24a, WAS AN | wanner I a | | |
| CAL | | | The resulting in t | no underlying co | iosa given iii i | PERFOR | MED? | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| MEDIC | | | | | | 1 YES 2 | NO NO | OF DEATH? | |
| | DID TOBACCO USE CONTR | PIRLITE TO CALISE C | NE DEATH VEC | | UNCERTAIN | I IOI | | 1 YES 2 NO | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? TELEASED | MODIL TO CAUSE C | 26. PLACE OF DEATH (| | UNCERIAIN | I JAJ | | | |
| Sic | EXAMINER? TELEASED | HOSPITAL: | 0. | THER: Nursing Nome 5 | O Brothese 4 | D 04 - 70 - 71 | | | |
| РНҮ | 27. MANNER OF DEATN | 28a. DATE OF INJURY | 26b. TIME O | F 28c. INJURY | AT | 28d. DESCRIBE HOW IN | JURY OCCURED | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th | 2 NO | | | | |
| | 2 Accident | 26s. PLACE OF INJURY building, atc. (Spec | / — At home, tarm, stree | t, factory, office | | 261. LOCATION (Street a | nd Number or Rural | Route Number, | |
| COMPLETED | 4 Nomicide determined | containing, area (Spor | City) | | | City or Town, State) | | | |
| 12 | 29a. CERTIFIER (Check only | CIAN: To the best of my know | riedge, death occurred at | the time, data and | place, and due t | o the cause(e) and man | nor so stated | | |
| M | | R: On the baals of examination | | | | | | (a) and manner as stated. | |
| ВСС | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | c. LICENSE NUM | | | D (Month, Day, Year) | |
| 00 | dulling 5 | 1/2 her | (15) | " | D 4214 | | | 100 00 | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, Prin | nt) | D 7414 | | AUGUS | 13/1995 | |
| | DR. WILLIAM E. BE | CKER, 902 SE | TON DRIVE | . CUMBER | LAND. M | D 21502 |) | | |
| | 31. DATE FILED (Month, Day, Year) | 32_REGISTRAR'S SIGN | ATURE | , | | | | | |
| 1 1 | AUG 1 6 1995 | Jalia Davidso | * Randall | | | | | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complemy med in by the fu | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical ex- |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR Helen H. Reges 08 1995 4:45 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign July 11,1907 1 M 2 F 216 40 2936 88 Ellerslie, Maryland Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Allegany Cumberland Nursing Home Cumberland 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Maryland LaVale 1 K YES 2 NO Allegany 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 24 Parkside Blvd 21502 US 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuban, Mexicon, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 YES 2 NO Specify: Specify: 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) IRVIN LOGSDON BESSIE BEAL 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) LEO W. LOGSDON R. D. 1. HYNDMAN, PENNSYLVANIA 15545 20e. METNOD DF DISPOSITION
1 Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE ty Buriel 2 ☐ Cremetion 3 ☐ 1 4\(\) Donation 5 ☐ Other (Specify) PALO ALTO CEMETERY 8/28/95HYNDMAN, PENNSYLVANIA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HARVEY H. ZEIGLER FUNERAL HOME, P.O.Box 23. PART I. Enter the disease, or complications that cau of the deeth. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, abock, or heert feliure. List only one cause on each line. Approximate Intervel Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) Pulman Veav DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA g Nome 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the filme, date end place, end due to the cause(e) end menner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER Veter V MI

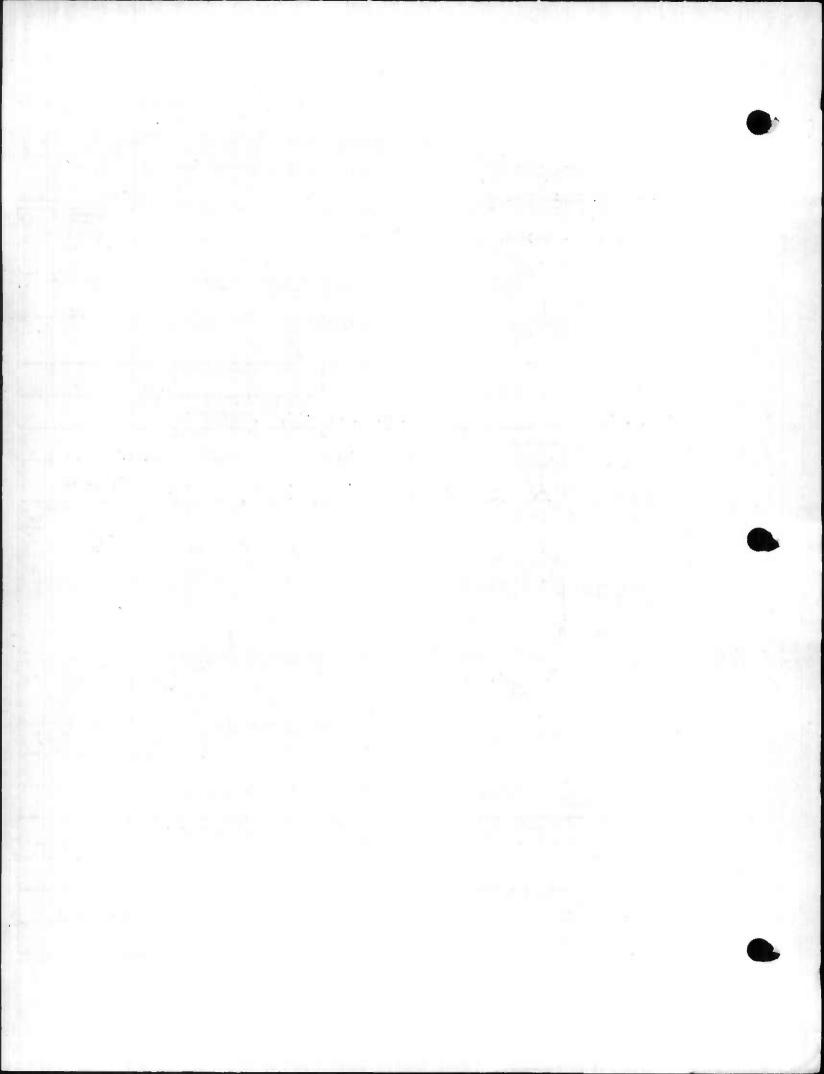
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ER 30 70 31. DATE FILED (Month, Day, Year)

32 REGISTRAR'S SIGNATURE
Java Davidson Randall AUG 2 8 1995



OF DEATH? 1 YES 2 NO

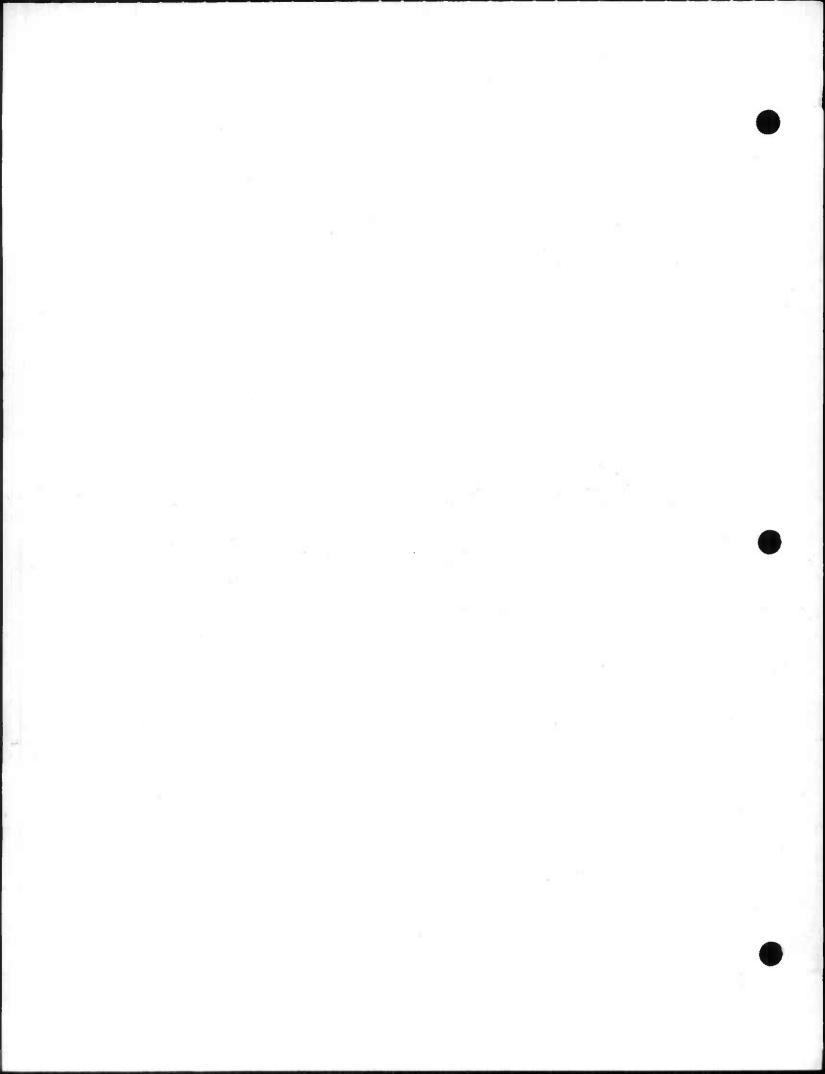


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| _ | REGISTRAR | | C | ERIIF | CATE | OF DEATH | REG | NO. | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) Shirley | lay M | | - | • • • | | MONTH | 2. DATE OF DEATH SOUTH DAY YEAR 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | 6. AGE (In yrs. In | | ith IF UNDER 1 YE | AR IF UNDER 24 HRS. | August | | | 0655 M | |
| | 220 62 6488 | | | | | | 7. DATE OF BIRT (Month, Day, Ye Feb. 2 | 1952 | | | |
| TOR | Calvert Memori | | ital | | | e Frede | | | alve | | |
| EC | 100. STATE 10b. COUNTY | | | 10c. CITY | , TOWN OR L | CATION | | | | 10d. INSIDE CITY | |
| L DIF | MD Calv | vert | | Broome's Island | | | | | 1 YES 2 NO | | |
| FUNERAL DIRECTOR | 8510 Church Rd. | | | | | 20615 | | 10g. C | USA | WHAT COUNTRY? | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 📦 | ARMED 33. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or N If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 18e. DE | CEDENT'S | USUAL OCCUI | ATION most of working | 16b. KIND O | F BUSINESS/H | NDUSTRY | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | | usew | | most of working | 70 | vn hoi | ne | | |
| ŏ | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S N | AME (First, Middle, M. | iden Sumame) | | | |
| BE (| Claude William | n Miste | | | | | rginia | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | . + + | | | | et end Number or Rura | | | | 20676 | |
| | Patricia A. Mag | Lulu | 7 | | | ve., Poi | | | | 20676 | |
| | Burlet 2 Cremation 3 memoral from State 4 Denetion 5 Other (Seccity) Broome's Is. Cem. 8-31-95 Broomes Is. | | | | | | | | | wn, State S., MD | |
| | 21. SIGNATURE OF PUNERAL SERVICE LAC | 1 1 | Ha. | | 22. NAM | sch Fune | ACILITY | Po | ort | blic, Md | |
| | 35 TART I. Enter the diseases, or co | omplications that | caused the de | eth. Do n | ot enter the | mode of dying, au | ch as cerdiec or i | | | Approximata | |
| | IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. Cau Cuu Cuu Cuu Cuu Cuu Cuu Cuu Cuu Cuu | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | |
| | PART ii Other significant conditions | contribution to d | and had and | | | | | | | | |
| EDICAL | PART ii. Other significent conditions | contributing to d | eeth but not r | resulting II | the under | ying ceuse given i | PE | S AN AUTOPS REORMED? | 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| Σ. | DID TOBACCO USE CONTR | IBLITE TO CAL | ISE OF DEA | TH YE | | I LINICEDTA | N D | | | 1 YES 2 NO | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | | | H (Check only | | 14 🖂] | | | | |
| Sic | | HOSPITAL: | ER/Oulpatient 3 | □ DOA | OTHER: | fome 5 - Reeldence | 8 Other (Specify | | | | |
| Y PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF II (Month, Day | | 28b. TIME INJU | OF 28c. | INJURY AT WORK? YES 2 NO | 28d. DESCRIBE H | | CCUREO | | |
| red BY | 2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide determined 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Homicide 1 Hom | | | | | | | er or Rural F | Route Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DESCRIPTION ON THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF | IAN: To the best of m | y knowledge, de | ath occurre | d at the time, | late end place, end du | s to the cause(e) end | manner ee at | ated. | and manner as stated | |
| | 296 SIGNATURE AND TITLE OF PENTIFIER | 0 | / | | , , , | 29c, LICENSE NU | | | | | |
| O BE | EMad/1. | DA | rece | _ | | D12- | 705 | ▶ X | 72 | (Month, Day, Year) | |
| 2 | Dr. Emad Albar | na | OF DEATH (ITE | М 27) (Туре, | Print) | Pri | nce Frede | rick, | MD | 20678 | |
| | 31. DATE FILED (Month, Day, Year) AUG 3 0 1995 | 32. REGISTRAR | s signature | lalle | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------|-------------------------|--------------------------------------|-------------------------------------------------|-----------------------|--------------------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATN | | 3. TIME OF DEATH | | | | |
| | Alda Virginia | | • | | | Монтн | 1842184" | | | | |
| | 4. SOCIAL SECURITY NUMBER | | (in yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | 8. 8 | IRTNPLACE (State or Foreign ountry) | | | |
| | 219-48-6267 | 1 🗆 M 2 💢 F | 64 YRS. | | | August 4,1 | | | | | |
| DC. | 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | |
| DIRECTOR | Washington County Hospital Hagerstown Washington | | | | | | | | | | |
| E E | | | | | | | 10d. INSL | | | | |
| | PA Fulto | 0 | Wa: | rfordsbu | | | | 1 TYES 2 XNO | | | |
| RA | 10e. STREET AND NUMBER | 200 | | 101 | . ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | |
| FUNERAL | Rt. # 1 Box 12 | 220 12. WAS DECEDENT EVER II | MIIS ABMED | 140 1110 050 | 17267 | | USA | | | | |
| | 1 Never Married 2 Merried | FORCES? 1 YES | 2XXNO | If yea, ap | ecify Cuben, Mexica 2 NO Specific | NIC ORIOIN? (Specify Years, Puerto Rican, etc.) | | RACE — American Indien, Black, White, etc. | | | |
| ВУ | 3 🕅 Widowed 4 🗌 Divorced | | -123 | 1 1 1 1 1 1 2 3 | ZALYMO Specif | у. | | Specify: White | | | |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | (Give kind of a | USUAL OCCUPATION | ON ast of working | 16b, KIND OF BL | SINESS/INDUSTR | | | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) Homemaker | | | | Own I | Iomo | | | | |
| COMPLETE | 17. FATNER'S NAME (First, Middle, Last) | | Homema | anel | 18 MOTNEO'S NA | ME (First, Middle, Meider | | | | | |
| Ш | Stewart Clingerma | an | | | | . Jerome | r Surreme) | | | | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) | | 195. MAILING | ADDRESS (Street a | | Route Number, City or Tox | vn, State, Zip Code |) | | | |
| F | James E. Smith, J | c. | Rt.# | 1 Box 12 | 20 Warf | ordsburg, | PA | 17267 | | | |
| | 20e. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Rem | oval from State 20b | PLACE AND DATE | OF DISPOSITION (Na | rme of | OATE 20c. LC | OCATION — City of | or Town, State | | | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE-OF FUNERAL SERVICE DIS | B. | Lack Oak | Mennoni | te Cem. O | 8/28/95 War | fordsbu | rg, PA 17267 | | | |
| | 1) 00 | the | | | Funeral | | | | | | |
| | P.O. Box 368 Hancock, MD 21750 23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| | snock, or neert fellure. | Liet only one cause on e | d the deeth. Do r ech line. | not enter the mo | de of dying, suc | h as cardiac or reap | olratory arrest, | Approximats Interval Between | | | |
| 1 1 | IMMEDIATE CAUSE (Finel disesse or condition | Chilee | 57115 | 15 10- | = 0111 | 2.5 | | Onset and Death | | | |
| | resulting in death) s. CONTESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| Z | Sequentially list conditions, a ANOX 10 ENCEPHOUS PATHY | | | | | | | | | | |
| | If any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | | | | |
| [윤 | cause. Enter UNDERLYING CAUSE (Disease or Injury | C. DUE TO (OR AS A | CONSEQUENCE OF | 3). | | | | | | | |
| CERTIFICATION | that initieted events resulting in death) LAST | | . CONSCOULINGE OF | <i>,</i> . | | | | | | | |
| | PART II Other elepiticent condition | a a a stall to the stall to | | | | | | | | | |
| S S | PART II. Other significant condition | s contributing to death b | ut not resulting | in the underlying | g cause given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | |
| MEDIC | | | | | | 1 YES : | 2 XNO | OF DEATH? | | | |
| | DID TOBACCO USE CONTI | RIBUTE TO CAUSE O | F DEATH YE | S I NO X | UNCERTAIN | | | 1 TES 2 NO | | | |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEAT | | OTTELKIAN | 10 | | | | | |
| YSIC | 1 TES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | atlent 3 DOA | OTHER: 4 Nursing Nom | e 5 🗆 Residence | 8 Other (Specify) | | | | | |
| F | 27. MANNER OF OEATN 1 Natural 5 Pending | 28e. DATE OF INJURY | | E OF 28c. INJ | URY AT NA | 28d. DESCRIBE NOW | INJURY OCCURE |) | | | |
| B | 2 Accident Investigation | 8/35/9 | 5 NA | | ES 2 NO | NIA | | | | | |
| | 3 Suicide e Could not be determined | 20a. PLACE OF INJURY building, atc. (Spec | At home, term, a | itreet, factory, offici | | 281. LOCATION (Street City or Town, Stete | end Number or Ru) | ral Route Number, | | | |
| <u> </u> | 290. CERTIFIER | | | | | NA | | | | | |
| COMPLET | | CIAN: To the best of my knowl R: On the basis of examination | | | | | | | | | |
| 1 11 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | - under investigatio | ii, iii iiiy opinion, o | 29c. LICENSE NUM | | | | | | |
| BE | John as Do | 29d. DATE SIGI | NED (Month, Day, Year) | | | | | | | | |
| 일 | 30. NAME AND MORES OF PERSON WHO | COMPLETEO CAUSE OF DE | ATN (ITEM 27) (Type, | Print) | 7 | 1151 | 010 | | | | |
| | 249 MILL 5 | | moter, | Ind. | 21 | 740 | | | | | |
| | 31. DANE FILED (Month Por 8 1995 | PEGIL PLANT SIGN. | Herlall | | | | | | | | |
| | DEL CO 1000 | 4 | ì | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

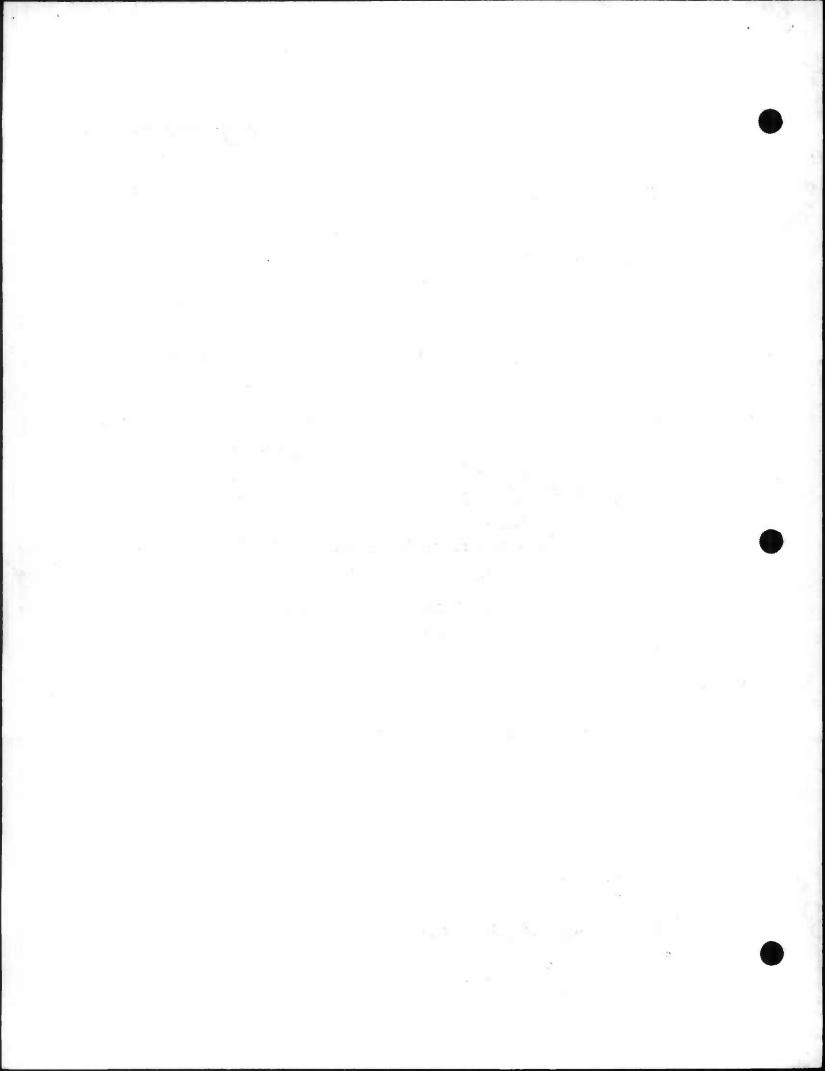
| ss that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and the Crap Day of Month and Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands Lands | and and wested hygene prior to borial, cremation, or removal. 8 any injury, or other traumatic event, the medical examiner must be notified at once |
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| OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. | INECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | Jous after ceatif with the State Sept. Or regulation mental hypere prior to burda, chematon, or emoval. 6m 28 is marked, or frem 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones. |
| TO THE HOSPITAL OR ATT | TO THE FUNERAL DIRECTO | IMPORTANT: H |

0

95 27483 Item4 10-5-95 FilmG728 W.H.Per F/H STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH JESSIE VIRGINIA STEVENS 1430 August 24 495 4. SOCIAL SECURITY NUMBER 299-32-9300 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreig DAYS HOURS 1 M 2 X F MAY 28, 70 YRS. 1925 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DORCHESTER GENERAL HOSPITAL DIRECTOR CAMBRIDGE DORCHESTER RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND DORCHESTER HURLOCK 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10t, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 311 MAIN STREET 21643 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ZINO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaz or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 📉 Never Married 2 🔲 Married BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) 6 **EDUCATOR** CHRISTIAN EDUCATION 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLINTON EARL STEVENS, SR. SUSIE FULLER BE 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RUSSELL STEVENS 6108 HURLOCK-SHILOH ROAD, HURLOCK, MD 21643 20e. METHOD OF DISPOSITION
1 ☑ Burlei 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata UNITY WASHINGTON CEMETERY 4 Donation 5 Other (Specify) 8/26 HURLOCK, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, P. O. BOX 207, 110 MAIN STREET, EAST NEW MARKET, MD 21631 23 FART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Melastala Unde Leny resulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CO that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES MO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nurel ng Home 5 Rasidenca 8 Other (Specify) 27. MANNER OF CEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 8 Could not be 4 Homicide detarmined ET 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and menner as stated. COMP 2 MEDICAL EXAMINER: On the nination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. BE 29c. LISENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

CAUSE OF DEATH (ITEM 27) (Type, Print)

New Street

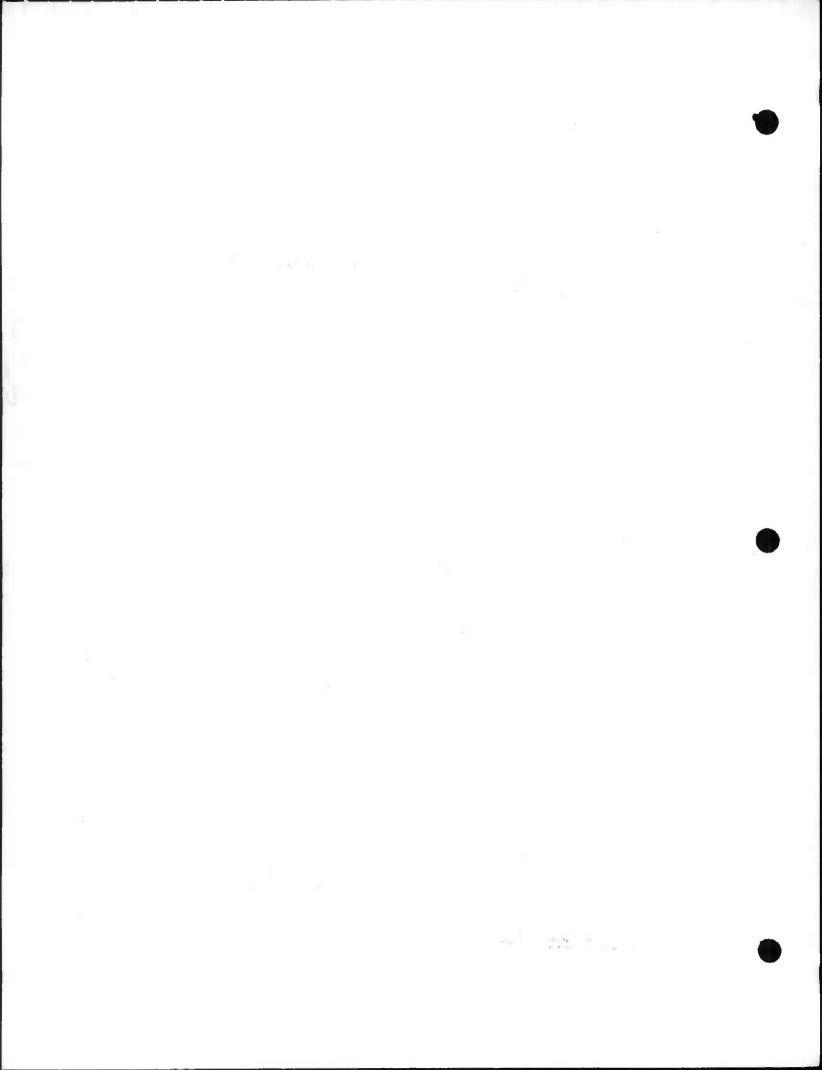


| | 1 - STATE REGISTRAR | CE | | ICATE | | | | MENTAL HYGIENI REG. NO. | E | | |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------|-----------------------------------------|-----------------------------------|--------------------|--------------------------------------------------|---------------------------------------|----------------------------|---------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | | 2. DATE OF DEATH | 3. TIME OF DEATH | | |
| | ROØGER | Q. S | HAFI | FER | | August | | | | YEAR | 11:58 PM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. last | birthday) | | | | 7. DATE OF BIRTH 8 | | 6. BIRTH | IPLACE (State or Foreign | |
| | 215-36-8511 | IXM2□F 55 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) Mar 9, 194 | O WV | | |
| | 9a. FACILITY NAME (If not institution, give street | if and number) | | 9b. CITY, | TOWN O | R LOCATIO | ON OF DE | ATH | | NTY OF D | |
| DIRECTOR | MEMORIAL HOSPITAL | | | CUM | BERL | AND | | | ALI | LEGAI | VΥ |
| 5 | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | | | | | | | | | |
| 2 | | | | Y, TOWN O | | ION | | | | | 10d, INSIDE CITY LIMITS? |
| | MD Alleg | any | OTO | dtown | - | | | | | | 1 TES 2 NO |
| RA | | | | | | ZIP CODE | | | | | VHAT COUNTRY? |
| FUNERAL | Route 1 Box 216 | | | | 1555 | | | USZ | | | |
| BY FU | 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 TYPES 2 TYPE IF YES, GIVE WAR OR DATES | | | f yes, spe | ENDENT O celfy Cubar 2 X NO | n, Maxicar | C ORIGIN? (Specify Yea i, Puerto Rican, etc.) | or No- | 14. RACE Black Speci | — American Indian, c, White, etc. |
| | | | | | | 21 | | | | | vhite |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co | mpleted) (G/w | e kind of a | USUAL OC | CCUPATIO | N it of working | a | 16b. KIND OF BUS | INESS/INC | DUSTRY | |
| الإ | | College (1-4 or 5 +) | | se retired.) | | | | | | | |
| M | 12 | Re | tire | d Ba | ker | | | Stroeh | | Bak | ery |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | NE (First, Middle, Maiden S | Surname) | | |
| H | Earl Shaffer 19a. INFORMANT'S NAME (Type/Print) | | | | | Lı | icre | tia (Reid) | | | |
| 임 | | | | | | | | oute Number, City or Town | | Code) | |
| | Wendell Shaffer, | | | | | | Keys | er. WV 26 | | | |
| | 20a, METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Remova | | natory or o | ther place) | , , , , , , , , , , , , , , , , , , , , | | | 1 | | City or To | |
| | 4 Donation 5 Other (Specify) Sunset Memorial Park 08/17 Cumberland, MD 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | Scarpelli Funeral Home | | | | | | | | | | |
| - 1 | Jumes 7 | Magrey | 1 | I Cr | mbe | rland | IM . F | 21502 | | | |
| | 23. PART . Enter the disesses, or con shock, or heart failure. Lis | nplications that caused the deal it only one cause on each line. | ith. Do r | not enter | the mod | de of dyle | ng, auch | ss cardiac or respir | atory sri | rest, | Approximate Interval Between |
| | | | | | | | | | Onset and Death | | |
| 1 | resulting in death) s. Due to on As a consequence open | | | | | | | | | | |
| _ | | DUE ROJOH AS A CONSEQU | UENCE OI | 3.7 | f ! | men | | 0101 | | 1 | - 0 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate b. Due to (D) AS A CONSEQUENCE OF): D. F. DUE TO (D) AS A CONSEQUENCE OF): D. F. DUE TO (D) AS A CONSEQUENCE OF): D. F. DUE TO (D) AS A CONSEQUENCE OF): | | | | | | | | | | |
| CAT | couse. Enter UNDERLYING | | | | | | | | | | |
| Ĕ | that initiated events CAUSE (Disease or Injury that initiated events CAUSE (Disease or Injury that Initiated events | | | | | | | | | | |
| FR | resulting in death) LAST d. Coronary ontery diseases 2 | | | | | | | | | | |
| | PART II Other elegisticant conditions constituting to death by | | | | | | | | | | |
| EDICAL | PART II. Other significant conditions contributing to death but not resulting in the funderlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO | | | | | | | | | | |
| | Do | Completion of cause of Death? | | | | | | | | | |
| Σ | DID TØBACCO VSE CONTRIE | & Vasulin | - a | 100 | 130 | P.O. | | _ | | | 1 TYES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | 26. PLACE | | S D N | | UNC | ERTAIN | | | | |
| PHYSICIAN: | EXAMINER? | IOSPITAL: | | OTHER | l: | | | | | | |
| H | 27. MANUER OF DEATH | Inpetient 2 ER/Outpetient 3 E | 26b. TIM | _ | ing Home 28c. INJU | | _ | 28d. DESCRIBE HOW IN | HIM OO | 011050 | |
| | 1 Dending | (Month, Day, Year) | | URY | WOR | ES 2 | | 286. DESCRIBE HOW IN | JURY OCC | CURED | |
| BY | 3 Suicide & Could not be | 26a. PLACE OF INJURY — At hom. | e, ferm, s | treet, facto | | 2 2 | | 261. LOCATION (Street an | od Alumbas | or Burni D | huda Alumbaa |
| COMPLETED | 6 Could not be determined | building, atc. (Specify) | | | .,, | | | City or Town, State) | I I I I I I I I I I I I I I I I I I I | or norm n | oute Number, |
| 9 | 29a. CERTIFIER | N. To the best of a large of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th | | | | | | | | | |
| N N | | N: To the best of my knowledge, dest | | | | | | | | | · · · · · · · · · · · · · · · · · · · |
| 8 | one) /2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as at | | | | | | | | - | | |
| 띪 | 296. SIGNATURE AND THE OF CERTIFIER | Thom | _ | | | 29c. LICE | NSE NUMI | BER // O | 29d, DATE | SIGNED | (Month) Day, Year) |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO IS | DEPLETED ONLY OF DEATH VALVA | 27) /×m- | Drint | لِـــــــــــــــــــــــــــــــــــــ | 1/ | 5 4 | 02 | Muc | 1/5 | 145 |
| ı | Dr. Shin Eung Kim, 90 Main Street, Westernport, MD 21562 | | | | | | | | | | |
| ŀ | Dr. Shin Eung Kim, 31. DATE FILED (Morith, Day, Year) | 32. AEGISTRAR'S SIGNATURE | wes | stern | port | , MD | 21 | .562 | | | |
| | AUG1 8 1995 | 32. REGISTRAR'S SIGNATURE | lall | | | | | | | | l |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation. or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netitied at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760



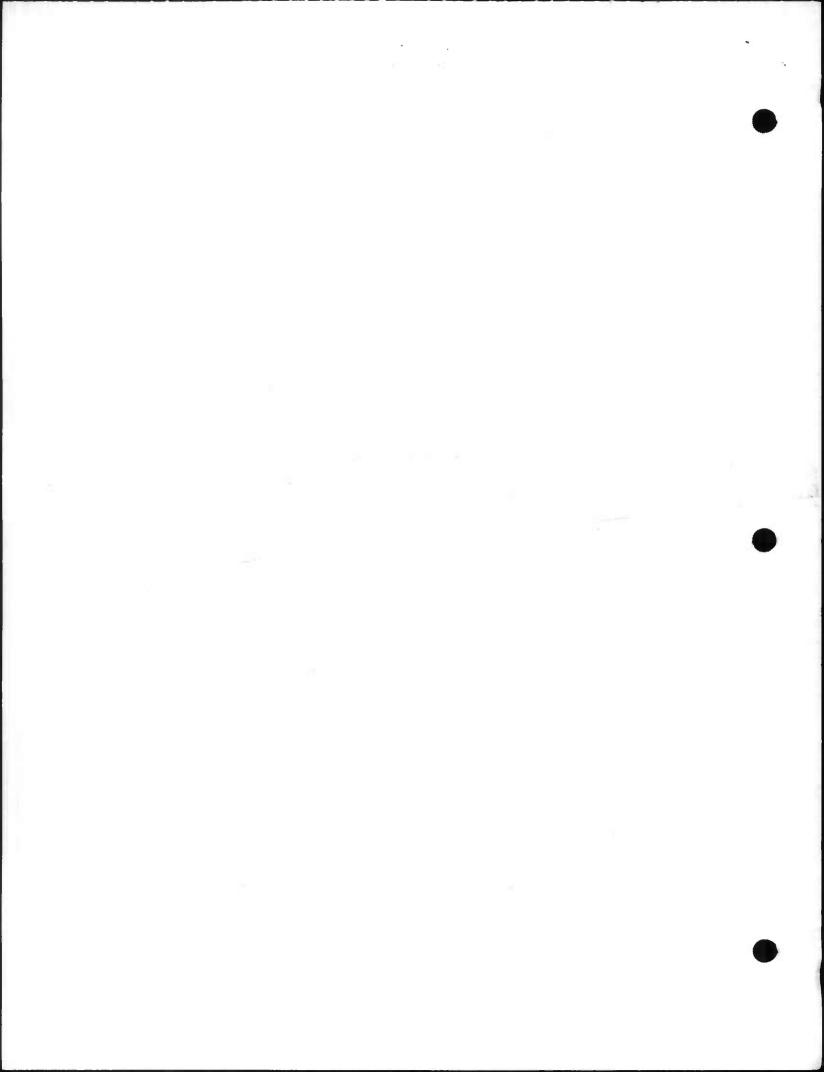
may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| the hospital or attending physician. | detached for use as the bunal-transit permit. Pages 1, 2, 3 should | once |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: Gours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Deat, of Health and Mental Hodele prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

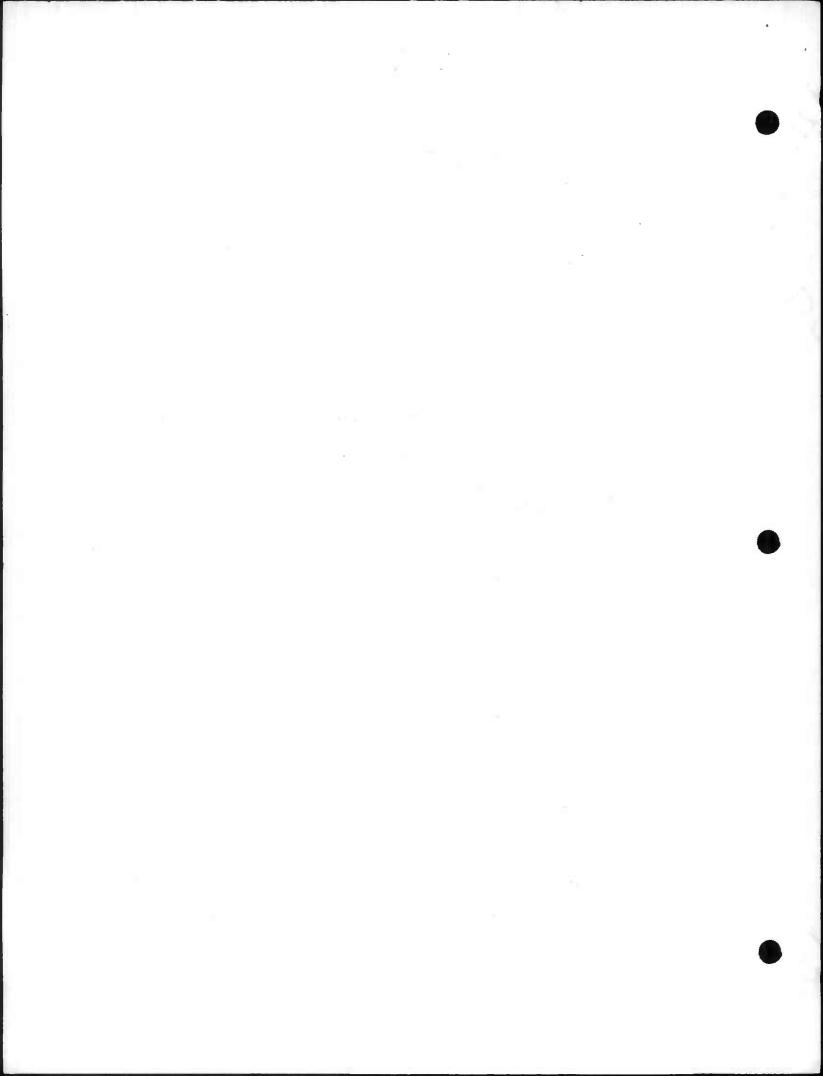
| | 1 - STATE REGISTRAR | | CE | RTIF | ICATE (| OF DEAT | TH | REG. NO. | E . | | | |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------|---------------------|------------------------------------|--------------------------------------|--------------------------------------------|---------------------------------|--------------------------------------------|-----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | | | | | | |
| | MARY | | | UGUST 23 | 23, 1995 1611 M | | | | | | | |
| R | 4. SOCIAL SECURITY NUMBER | 5. SEX | birthday) | MONTHS DAYS HOURS MIN | | | 7. DATE OF BIRTH 3-10-08 | | WASH | LACE (State or Foreign | | |
| | 577-01-8584 | 577-01-8584 1 \(\text{i} \) \(\text{M} \) \(\text{2} \) \(\text{F} \) \(\text{87} \) FACILITY NAME (If not institution, give street and number) | | | | | | -10-08 | | | | |
| | 14009 LIGHTHOUSE DR. | | | | | WN OR LOCATI | D C E C | ** | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | IEK | | |
| RE | MD. WORCE | | | CEAN C | | | | | 1 | IOd, INSIDE CITY | | |
| | 100. STREET AND NUMBER | | | CEAN C | | | | | | YES 2 NO | | |
| FUNERAL | 14009 LIGHTHOUSE | | | | 21842 | 1 | | | USA | AT COUNTRY? | | |
| ON | 11 MARITAL STATUS | | | IED | 13. WAS | | | RIGIN? (Specify Yes | _ | 4. RACE - | - American Indian, | |
| ВУ F | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 | YES 2 NO | 0 | II ye | yes 2 NO | Specify: | erto Rican, etc.) | | | White, etc. | |
| | 15. DECEOENT'S EDU | ICATION | 140- 050 | COCNIC | 1 | | | | | WIII 1 E | | |
| ETE | (Specify only highest grade | completed) | lije. l | e kind of i Do NOT ui | se retired.) | g most of working | ng | | JUSINESS/INDUSTRY | | | |
| PL | 12 | College (1-4 or 5+) | , Hoi | MEMA | KER | | | Own | HOME | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | irst, Middle, Melden | Surname) | | | |
| BE (| J. ERNEST BURF | ROUGHS | | | | | Y SCHR | | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) M. JUDITH SYLVEST | CED | 196. | 4009 | AODRESS (St | HOUSE | or Rural Route | Number, City or Town | n, State, Zip (| 20de) | 842 | |
| | 20a. METHOD OF DISPOSITION | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SAL ISBURY CREMATORY 8-24 SAL ISBURY MD. | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNCTIAL SERVICE LI | DENSEE // ./ | 7 | | | | SS OF FACILITY | | | | | |
| | Jem & G | Mrul | ` | | ULL | RICH F | UNERAL | HOME | BERLI | N, M | D., 21811 | |
| | 23. PART I. Enter the diseases, or shock, or heart fallure. | complications thet | caused the des | th. Do r | not anter the | moda of dyl | ing, such as | cardiac or respi | ratory arre | st, | Approximate | |
| | | | | | | | | | | | Onset end Dasth | |
| | disease or condition s. Warran Consequence of: | | | | | | | | | TYM | | |
| _ | | | | | | | | | | | | |
| 2 | Sequentially list conditions, If any, leading to immediate Cause First LINDERD VINC. | | | | | | | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | DOE 10 (| OH AS A CONSECU | JENCE O | F): | | | | | | | |
| DICAL CERTIFICATION | d | | | | | | | | | | | |
| SAL | PERFORMED? | | | | | | | | | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO | | |
| EDIC | C | | | | | | | | OMPLETION OF CAUSE OF DEATH? | | | |
| Σ | DID TORACCO LISE CONT | DIRLITE TO CAL | ISE OF DEAT | L VE | S D NO | N UNIC | EDTAIN F | , | | 1 | ☐ YES 2 ☐ NO | |
| PHYSICIAN: ME | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 126. PLACE OF DEATH (Check only/one) | | | | | | | | | | | |
| SIC | EXAMINER? | HOSPITAL: | ER/Outpatient 3 | DOA | OTHER: 4 Nursing | Home 8 The | uldence 6 🗆 | Other (Specify) | | | | |
| F | 27. MANNER OF OEATH Netural 5 Pending | 28a. OATE OF I (Month, De | | 28b. TIM INJ | E OF 28c | INJURY AT WORK? | 28d. | DESCRIBE HOW IF | JURY OCCU | RED | | |
| B | 2 Accident Investigation | - | | | | YES 2 | | | | | | |
| 8 | 3 Suicide 8 Could not be 4 Homicide determined | building, e | INJURY — At homole. (Specify) | e, larm, r | dreet, factory, | offica | | LOCATION (Street e City or Town, Stete) | nd Number o | r Rural Rou | ite Number, | |
| <u></u> | 290. CERTIFIER CERTIFYING PHYSI | ICIAN: To the heat of a | - beautides des | | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINE | ICIAN: To the best of r IR: On the bests of ext | amination and of in | n occum veatigatio | n, in my opinio | date end place, on, death occur | , end due to the red at the time, | date end place, and | ner se stated | f. cause(a) s | and menner se stated. | |
| | 296. SIGNATURE AND TAKE OF CERTAFE | | //// | | of care | - | ENSE NUMBER | | 29d. DATE | | | |
| # | 10/ | - | 4 | | W | IC | 267 | 78 | ▶ 8 | -27 | 1-25 | |
| 0 | 30. NAME AND ADDRESS OF PERSON WH | | E OF DEATH (ITEM | 27) (Type, | Print) | | | 01120 | 11 | 10 | 1461 | |
| 8 | UNVIL (OLEA | 11, 1110 | 1756 | = (| ARK | UST. | _ SY | 145000 | 7/10 | Ni | 21801 | |
| | 31. DATE FILED (Month, Day, Year) | 32. BIGISTRAR | S SIGNATURE | 4 . 4 | | | | | / | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF HE | ALTH AND I | MENTAL HYGIEN REG. NO | | | | | | |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------|--------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last SOPHIA | NMI | SHECKE | LLS | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 213-20-7767 | 1 □ M 2 XF 89 | In yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 8. BII | RTNPLACE (State or Foreign Unit III) | | | | |
| POR | BERLIN NURSING | HOME | | BERLIN | LOCATION OF DE | ATN | | | | | | |
| DIRECTOR | 100. STATE 10b. COUN WOL | RCESTER | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 MANO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 266 OCEAN PARKY | VAY | , | | 21811 | | 10g. CITIZEN O | | | | | |
| B≺ | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 _ YES IF YES, GIVE WAR OR DO | 2 NO | | Ify Cuben, Maxica | IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.) | В | lack, White, etc. | | | | |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest gra- | UCATION de completed) Collège (1-4 or 5+) | | , | | | | , | | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Leat) JOSEPH BURY | | | | | ME (First, Middle, Melden Y BURY | G. NO. EATN DAY 1995 1.50 P M 1:50 P M 1:50 P M S. BIRTNPLACE (State or Foreign Country) 9. COUNTY OF DEATN WORCESTER 10d. INSIDE CITY LIMITS? 1 | | | | | |
| 10 | 190. INFORMANT'S NAME (Type/Print) SELMA M. LYNCH 200. METHOD OF DISPOSITION | | 2411 (| CEAN PIN | es Ber | RLIN, MD., | 21811 | SBURY, MD., 21811 | | | | |
| | 1 Buriel 2 Scremetion 3 Re 4 Donation 5 Other (Specify) | moval from State | netery, crematory or of | CREMATOR | r place) | | | | | | | |
| | - I d capter | | | | | | | | | | | |
| CERTIFICATION | shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| THE CHOOL | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 244. WAS AN AUTOPSY PERFORMED? 1 YES 2 K NO | | | | | | MED? | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outp | 2 7 704 | 6 Other (Specify) | | | | | | | | |
| | 27. MANNER OF DEATH 1 X Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 26c, INJUI | RY AT | | NJURY OCCURED | | | | | |
| ETED BY | 3 Suicide 6 Could not b 4 Homicide detarmined | 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | al Route Number, | | | | |
| COMPLE | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner as stated. | | | | | | | | | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIC | land M | 5 | | D2950 | | | | | | | |
| 6 | GREGORIO BELLO | SO 4421 BEE | CHWOOD P | | SFIELD | MD 21817 | | | | | | |
| 31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE AUG 2 5 1995 Fully Danies - Research | | | | | | | | | | | | |



1. DECEDENT'S NAME (First, Middle, Last)

CLARENCE WILBUR SHOOK 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) JF UNDER 1 YEAR IF UNDER 24 HRS. 214-07-1019 1 X M 2 83 YRS Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give stre 9b, CITY, TOWN OR LOCATION OF DEATH DIRECTOR MEMORIAL HOSPITAL CUMBERLAND RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION MARYLAND ALLEGANY RAWLINGS permit. 10e, STREET AND NUMBER FUNERAL ROUTE 3, BOX 263 use as the burial-transit 21557 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried BY 3 X Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION (Sne funeral director, page 5 should be detached for Elementery/Secondary (0-12) College (1-4 or 5+) TRUCK DRIVER COMPL once. 17. FATHER'S NAME (First, Middle, Last) JOHN ALLEN SHOOK notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 EILENE SINES MILLER STREET Раде 6 тау be must be 20e. METHOD OF DISPOSITION
1 [XBuriel 2] Cremetion 3] Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 4 ☐ Donation 5 ☐ Other (Specify) BIERTOWN CEMETERY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE death. n and completely filled in by the to bunal, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory strest, shock, or heart failura. List only one cause on each line IMMEDIATE CAUSE (Final disesse or condition_ a Lung Carcinoma event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate been signed by the attending physician it, of Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL Chronic Obstructive Pulmonary Disease shows any DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖾 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h with the State I HOSPITAL: I Dinpetient Z ER/Outpetient 3 DOA OR ATTENDING PHYSICIAN 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) ö 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28e. DATE OF INJURY marked, 1 X Natural 1 YES 2 NO В After death Investigation 2 Accident Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28 is COMPLETED DIRECTOR: A tem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIER WITHIN 72 MINIMAR IN TO THE IMPORTANT: If It FUNERAL C 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 133280 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GUPTA JOHNSON HEIGHTS MEDICAL BUILDING CUMBERLAND MD 21502 31. DATE FILED (Month, Day, Year) 2. REGISTRAR'S SIGNATURE 2 3 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 3. TIME OF DEATH AUGUST 18 199 7:30 PM 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Dec. 30, 1911 MARYLAND 9c. COUNTY OF DEATH ALLEGANY 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. WHITE 16b. KIND OF BUSINESS/INDUSTRY CONCRETE COMPANY 18. MOTHER'S NAME (First, Mickelle, Maiden Surname EMMA BLANCH DIEHL - LAVALE, MD 20c. LOCATION — City or Town, State DATE RAWLINGS. GEORGE-UPCHURCH FUNERAL HOME GREENE ST., CUMBERLAND, MD Interval Between Onsst and Daath 1 Month 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) ▶ August 22, 1995

E. 11 FEB.

ALTIMORE, MARYLAND 21215-0020

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| 4 | The |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 3 hours after |
| 2 | NDING |
| 3 | III. |
| 5 | OB |
| | PUTAL |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH EORGE 1245 August evenson 995 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH a. BIRTHPLACE (State or Foreign 86-16-3342 75 1 X M 2 - F DAYS HOURS YRS 10-10-1919 Pages 1, 2, 3 should So. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD 00 1 2 YES 2 | NO permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21817 funeral director, page 5 should be detached for use as the burial-transit be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEOENT'S EDUCATION ecity only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) abovER ONCE. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surn STEVENSON To SEOIGE EMMA 8 notified 19a. INFORMANT'S NAME (Type/Print) 19h MAILING ADDRESS (S) 2 ANTHONY E. 314 Coro 21817 pe 20a, METHOD OF DISPOSITION
1 C Burlel 2 Cremation 3 Page 6 may 206 PLACE AND DATE OF DISPOSITION (Nan PATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) aw Sonia examiner 21. SIGNATURE OF EMPERAL SERVICE LICEN ANHANG E. WAID ESS OF FACILITY death. Funcial Home Cove Fold pletely filled in by the medicai 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line. Interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death cremation, the disease or condition Cerahrovasc event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) in and com to burial, i E 83 traumatic CERTIFICATION Sequentially list conditions. Hygiene pri if any, leading to immediate cause. Enter UNDERLYING a CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 9 the atter Mental injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO signed by the shows any venous COMPLETION OF CAUSE 1 | YES 2 | NO 1 | YES 2 | NO been . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) ltem. certificate h HOSPITAL OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpetient 3 - DOA 4 - Nurs ng Home 5 - Realdenca 6 - Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, with (1 Natural 1 YES 2 NO В death 2 Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 6 Could not be DIRECTOR: after 4 Homicide 28 determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If Item 23 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNAPURE AND TITLE OF CERT BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day) 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

AT RESISTENT RUG AT THE

AUG3 0 1995

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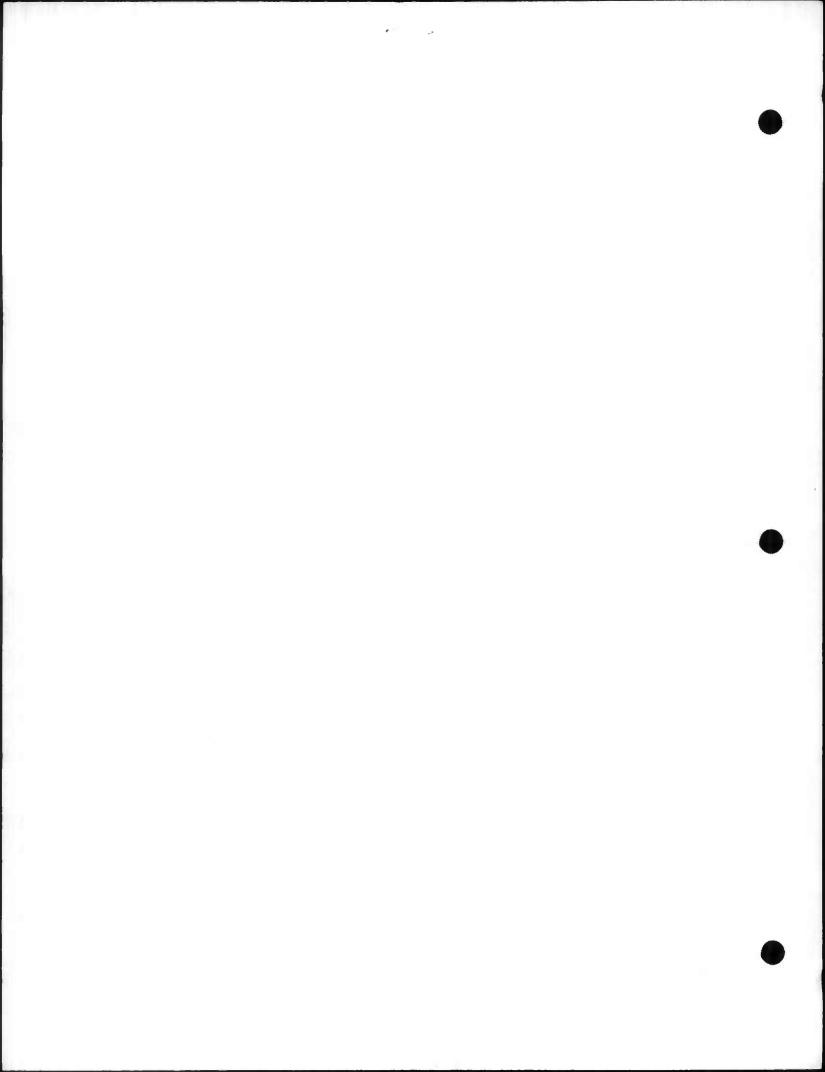
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DIVISION OF VITAL

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, | Addedta + | | | | | | | | | | HEG. NO. | | | |
|--------------------------------------------------------------------------------------------------------|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------|---------------|-------------------------------------------------------------------------------|---------------|----------------|----------------------|-----------|----------------------|-----------------------------------|--------------|--------------|---------------------------------------------|
| | | , | 100 | tin orma | NIT? | | | | | | | 2. DATE O | | W | YEAR | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | | tin SWEE | | | | | | | | | ıst 28 | 3, 19 | | 1:27 рм |
| | | 216-22-562 | | 5. SEX | | (In yrs. last | | IF UNDER | 1 YEAR DAYS | IF UNDER | 2001 | 7. DATE O (Month, | Day Mari | | Country | PLACE (State or Foreign |
| pp | | Feb. 27, 1907 Maryland | | | | | | | | land | | | | | | |
| 3 should | 000 | Be. FACILITY NAME (If not institution, give street end number) Garrett County Memorial Hospital 9b. CITY, TOWN OR LOCATION OF DEATH Oakland 9c. COUNTY OF DEATH Garrett | | | | | | | | | | | | | | |
| €. | DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | | | | |
| Pages 1, | EC | 10a. STATE | 10b. COUNT | | | | 10c. CIT | Y, TOWN C | | | | | | | T | 10d, INSIDE CITY |
| <u></u> | E G | MD | Gar | rett | | | | 0ak | lan | d | | | | | | LIMITS? |
| permit. | AL | | | | | | | | | | | 10g. CITI | ZEN OF W | HAT COUNTRY? | | |
| 2 | FUNERAL | 623 East High Street 21550 USA | | | | | | | | | | | | | | |
| TAND 21215-0020 the hospital or attending physician. detached for use as the burial-transit | 1 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | | 13. | WAS DEC | CENDENT C | OF HISPAN | IC ORIGIN? | (Specify Yes | or No- | 14. RACE | - American Indian, |
| P 200 | BY F | 1 Never Married 2 3 Widowed 4 Divo | | FORCES? 1 IF YES, GIVE W | | | If yes, specify Cuban, Mexican, Puerto Rican, etc.} 1 ☐ YES 2 [X NO Specify: | | | | | can, etc.) | Black, White, etc. Specify: White | | | |
| Z15-0020 attending physic ise as the bunal | ED B | | | | | | | | | | | | | | | MILLE |
| age of age | I | (Specify only | EDENT'S EDU- highest grade | completed) | | /Gh | EDENT'S re kind of v Do NOT us | work done | CUPATIO | DN ost of working | ng | 16b. F | CIND OF BUS | INESS/IND | USTRY | |
| pital or of for u | 1 2 | Elementary/Secondary (0 | -12) | College (1-4 or 5 a | +) | | | | | | | | | | | |
| AND he hospit detached | COMPLET | 17. FATHER'S NAME (First, Mi | iddle, Last) | | | пеа | ring | Sign | it S | peci | | | ounty | | ol S | System |
| 1 2 2 2 |) U | | | Marti | n | | | | | Eva | | WE (FIRST, MIC | ddle, Melden | , | kins | |
| retained by the hospit 5 should be detached | 8 | 19a. INFORMANT'S NAME (7) | /pe/Print) | *************************************** | | 19b | MAILING | ADORESS | (Street s | | | lorda Mirmba | r, City or Town | | | |
| 41 | | Carol Janda | | | | | | | | | | | | | | on 98263 |
| may be | | 20e. METHOD QE DISPOSITI | ON | | 206 | PLACEA | | | _ | | -016 | DATE | | CATION - | | |
| E 6 ma | | 1 Buriel 2 1 Crematio 4 Donation 5 Other | | oval from State | cen | mega | netory or of | her place! | | | | | Mor | | | |
| Pag in | | 21. SIGNATURE OF FUNERAL | L SERVICE LIG | ÉMREE (| | ano Ba | 010 | | | ND ADDRE | SS OF FAC | | Home | | wii, | WV |
| DALIMORE, 24 hours after death. Page 6 may be filled in by the funeral director, page on, or removal. | | ► 63. M | D | The ! | | | | | | | | | | | n le la | nd, Md 21550 |
| | | 23 PART I Enter the di | M 1 | - Damer | | 4.45 - 4 - | 41 | | | | | | | | | nd, Md 21330 |
| | | | ant failure. | List only one cau | se Dn e | ach line. | ith. Do n | Dt anter | tna mo | ida of dyl | ing, auch | aa cardia | c or reapli | ratory arre | est, | Approximate Interval Between |
| completely filled right. | | | IMMEDIATE CAUSE (Final disease or condition at horocal proties condition disease or condition at horocal proties condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease or condition disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disease disea | | | | | | | | | | | | | |
| ompletely cremat | | a. atherosclerotic cardiovascular disease 5 years | | | | | | | | | | | | | | |
| executed within and completely buffal, crema | | | _ | DOE TO | (OR AS A | CONSED | UENCE OF | ·}: | | | | | | | | |
| and and and | CATION | Sequentially list conditions, If any, leading to immediate DUE TO (DR AS A CONSEDUENCE DF): | | | | | | | | | | | | | | |
| ficate be a physician ne prior to | 8 | cause. Enter UNDERLYING | | | | | | | | | | i | | | | |
| certificate ding physical dygiene pri | RTIFI | CAUSE (Disease or Injury that initiated events DUE TO (DR AS A CONSEDUENCE OF): | | | | | | | | | | | | | | |
| E 5 - C | 1 111 | resulting in death) LAST | | | | | | | | | | | | | | |
| the death certify the attending of Mental Hygies | O | PART II. Other algolifice | nt condition | a contributing to | death h | ut not r- | eultina l | n the v- | darlate | | due to 5 | Dart I - | 4- 140 - 200 | | 1 | |
| 2 88 | AEDICAL | valvular h | | | Seatt 0 | ST HULTE | outing l | ure un | oeriyini | y couse (| PVEU IU E | | 4a. WAS AN | MED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ulires that signed Health a | | _varvarar t | icart (| a racase | | _ | | | | | | _ 1 | YES 2 | X NO | | COMPLETION OF CAUSE OF DEATH? |
| requires been signe t. of Health | 45 | DID TOPACCO III | SE CONT | DIDLITE TO CA | LICE C | E DEAT | 11 V= | <u>. D.</u> | 10 = | 11110 | EDTA: | | | | | 1 TES 2 ND |
| The law are has be are Dept. | AN | DID TOBACCO US | | CIBUIE 10 CA | | PLACE | | _ | | UNC | EKIAIN | | | | | |
| SICIAN: The law requestrificate has been the State Dept. of or item 23 sho | SICIAN: | EXAMINER? | | HOSPITAL: | | | | OTHER | 1: | | | | | | | |
| Sicial | | 27. MANNER OF DEATH | | 1XXinpatient 2 28a. DATE OF | | etient 3 [| 28b. TIME | | ing Hom | | - Y | Other (| | HIEW OCC | Unfo | |
| F star | | 1 Netural 5 🗆 f | Pending | (Month, De | | | INJ | | WO | PRK? | - 1 | ∡eu. DEŞCI | RIBE HOW IN | MUNT OCC | UNED | |
| Appling After death | | 3 Suitable | nvestigation | 28e. PLACE OF | F INJURY | - At hom | ne, farm. = | treet, fecto | | | | 28f. LOCAT | ION (Street a | nd Number | or Russ S- | usha Mumhar |
| TOR: after | | | Could not be letermined | building, | atc. (Spec | ify) | | | | - | | City or | Town, Stete) | IN INUITION! | or murali Mo | rare reumust, |
| DIRECTOR OF THE | | 29e. CERTIFIER 1 X CERTI | EVING BUYER | NAM: To the best of | man de la la la la la la la la la la la la la | | | | | | | | | Second - | | |
| N A R = | M | (Check only one) 2 MEON | CAL EXAMINE | CIAN: To the best of ax | my knowi | reage, desi | medication | a at the ti | me, date | end place, | end due t | to the cause | (e) end man | ner as state | d. | and manner as stated. |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 h | 8 | | | | - THE PERSON | · erroror III | - Jangarior | 1, III IIIY O | willon, d | | | | vo prace, and | | | |
| 표표 등 전 | 핆 | 29b. SIGNATURE AND TITLE | TA A | | | de | D | | | | NSE NUME | BER | | | | Month, Day, Year) |
| 663 | 유 | 30. NAME AND ADORESS DF | PERSON WHI | COMPLETED CAUS | E DE DE | ATH OTTER | 27.0 | Defeat | | D25 | / 39 | | | Aug | gust | 29, 1995 |
| | | | | | | | | | i d | 4 MD | 2150 | 20 | | | | |
| | | Walter K. N | taumam ber) | 32 REGISTRAL | B'S SIGN | ATHE | | ACC: | Laen | C MD | 2132 | 20 | | | | |
| | | 31. DATE FILED (Month, Day,) | 1995 | Talin Das | ed son | P | 10 | | | | | | | | | |
| | السبا | | .000 | The same | weak. | - Carba | 14 | | | | | | | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

| 13146, |
|----------|
| BOX |
| P.0. |
| RECORDS, |
| VITAL |
| OF |
| DIVISION |

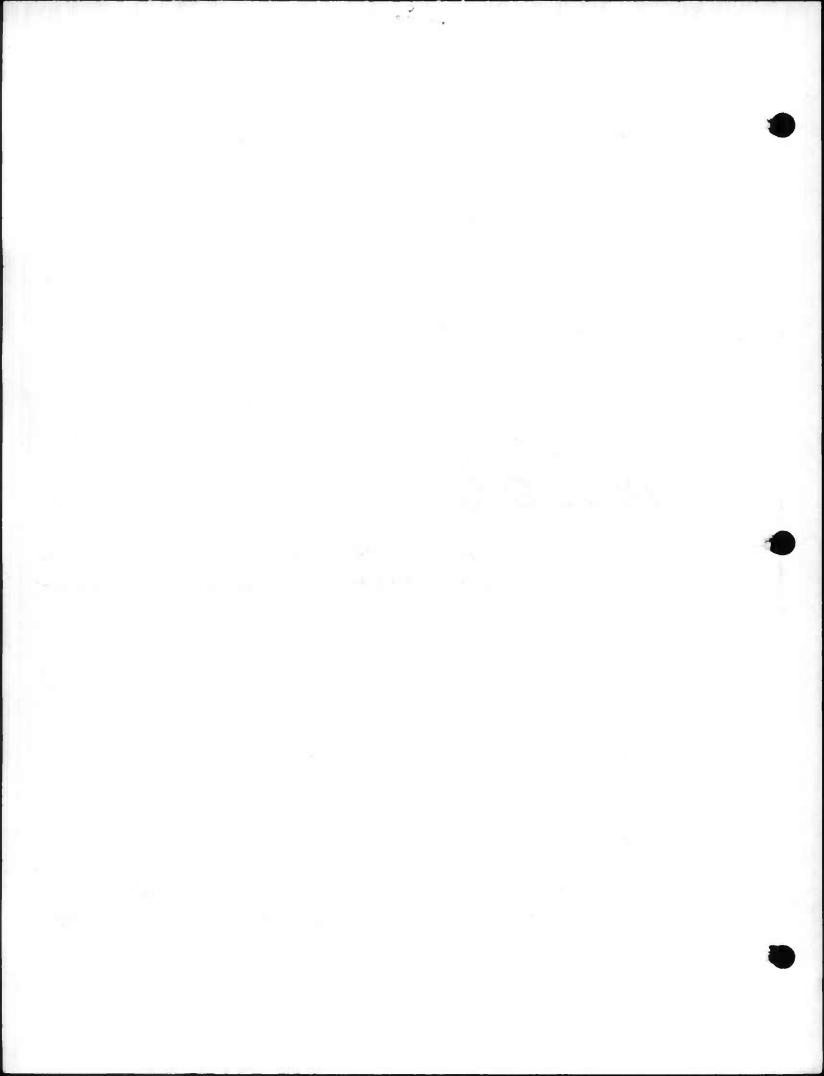
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.7 Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT | OF HEALTH AND MENT | AL HYGIENE |
|--------------------------------|--------------------|------------|
| CERTIFICATE | OF DEATH | REG. NO. |

| FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIE | | |
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| 1. DECEDENT'S NAME (First, Middle, Las | it) | - | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| Thomas | Mavo | Tapscott | | | AMAUST. | 19 19 | 95 4:00 a M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | *** | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | a. BIRTHPLACE (State or Foreign |
| 217 - 03 - 7621 | | .00 YRS. | DAYS DAYS | HOURS MIN. | Nov 20, | | Virginia |
| 9a. FACILITY NAME (If not institution, give | | 1 | | R LOCATION OF DE | EATH | | TY OF DEATH |
| 9411 Tuckerman | | | Seabro | JK. | | PLIN | ce George |
| 10e. STATE 10b. COU | | 10c. CITY, T | OWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| Maryland Pri | nce George | Seab | rook | | | Lis accord | 1 🔀 YES 2 🗌 NO |
| 9411 Tuckerman | Street | | 100 | . ZIP CODE 20706 | | USA | |
| 11, MARITAL STATUS | 12. WAS DECEDENT EVER I | IN U.S. ARMED | | | IIC ORIGIN? (Specify) | ea or No— | 14. RACE — American Indian, |
| 1 Never Merried 2 Merried | FORCES? 1 YES | 2 MO DATES | | 2 X NO Specify | n, Puerto Rican, etc.) | - 1 | Black, White, etc. Specify: |
| 3 Widowed 4 Divorced | | | | | | | White |
| 15. DECEDENT'S E (Specify only highest gr Elementary/Secondery (0-12) | DUCATION side completed) College (1-4 or 5+) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | k done durina moi | | 16b. KIND OF B | USINESS/INDU | JSTRY |
| Grade 3 | | Mechanic | : | | Autom | obile (| Garage |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Melde | | |
| Henry Tapscott | | | | Sarah : | Sauers | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DDRESS (Street a | nd Number or Rural I | Route Number, City or To | own, State, Zip (| Code) |
| Phyllis Sczuka | | 9411 1 | uckerma | an Stree | t, Seabro | ok, Mai | ryland 20706 |
| 20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 R | emovel from State | b. PLACE OF DISPOSITI | | | | | Olty or Town, State |
| 4 Donation 5 Other (Specify) | | Ivy Hill C | | VD ADDRESS OF FA | | urei, | Maryland |
| 6///-11- | 1 () // | , | Dona. | ldson Fu | neral Hom | | |
| NeW If L | in Xoully | ٢. | | | | | ryland 20707 |
| 23. PART I. Enter the diseases | or complications that cause re. List only one cause on a | ed the death. Do not each line. | antar tha mo | de of dying, suc | h aa cardiac or rai | piratory arra | ast, Approximata interval Between |
| IMMEDIATE CAUSE (Final | A DESCRIPTION OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF | | . / | | / | | Onset and Death |
| disease or condition resulting in death) | · Conge | stre 1 | Heart | Fail | une | | 10 years |
| | DUE TO (QA AS | A CONSEQUENCE OF: | - A- | and d | me e | | 14000- |
| Sequentially list conditions, | b. DUE TO (OR AS | A CONSEQUENCE OF: | arri | TINK | 11101 | | 1000 |
| if any, leading to immediata cause. Enter UNDERLYING | | | | | | | |
| CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| resulting in death) LAST | d | | | | | | |
| PART II. Other algnificant condit | lone contributing to death | but not resulting in | the underlying | a cause alven in | Part I 24a WAS | AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| THE THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF T | Total Control of Control | out not resulting in | and discorrying | g caosa giran in | PERF | ORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | <u> </u> | 1 TYES | 2 NO | OF DEATH? |
| | | | | | | | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 28 PI | LACE OF DEATH (C) | back only one) | | |
| EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Ou | | THER: | | 6 Other (Specify) | | |
| 27. MANNER OF DEATH | 26a. DATE OF INJURY | 28b. TIME | | JURY AT | 28d. DESCRIBE HO | V INJURY OCC | CURED |
| 1 Natural 5 Pending | (Month, Day, Year) | INJUF | | YES 2 NO | | | |
| 2 Accident investigation 3 Suicide a Could not | 28e. PLACE OF INJUR | IY — Al home, farm, str | eet, factory, offic | :0 | | | or Rural Route Number, |
| 4 Homicide determine | | ecity) | | | City or Town, Sta | ito) | |
| 29e. CERTIFIER 1 CERTIFYING PI | TYSICIAN: To the best of my kno | wiedge, death occurred | at the time, date | and place, end du | s to the cause(s) and i | nanner as state | ed. |
| (Orbon Orby) | | | | | | | e cause(e) and manner as stated. |
| 29b. SIGNATURE AND TITLE OF CERT | FIER APP | 13/20 11 | 1 | 29c. LICENSE NU | MBER | 29d. DATE | E SIGNED/Month. Onc. Year) |
| Time | ill /// | Mal | 11) | D39 | 532 | | 2119195 |
| 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF O | ATH (ITEM 27) (Type, P | Print) | co le | 70 m 0 0 51 | 2 10 | une / whi |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE . | VIII | ice y | vige " | · Ca | 401111 |
| AHG 9 9 100 | 15 The Manuels | so Rad-11 | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| HOSPITAL OR ATTENDING | FUNERAL DIRECTOR: After | 1 within 72 hours after death | RTANT: If Item 28 is mai |
| HT CF | HT CL | be filed | IMPO |

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MARYDRITA

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KORERLEM 32. REGISTRAR'S SIGNATURE

Julia Davidson Rardall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 1995 AÜĞUST 03:19 A THOMAS DERRELL WILLIAM 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1**X**XM 2 □ F DAYS HOURS DEC. 17, 25 1969 216-14-1831 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Oc. COUNTY OF DEATH DIRECTOR BALTIMORE BALTIMORE CITY JOHN HOPKINS HOSPITAL 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND CHARLES WALDORF 1 XXYES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? #880 HOLLY TREE LANE 20602 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 1XXNever Married 2 Married BΥ 3 Widowed 4 Divorced BLACK 15 DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life, Do NOT use retired.) ᆸ Elementary/Secondary (0-12) NONE NONE 10TH GRADE 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First Middle Maiden Surname) ELIZABETH LORRAINE BELLFIELD THOMAS FRANCIS WILLIAM HART 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) NADINE THOMAS #1096 DORSET DRIVE, WALDORF, MARYLAND 20s. METHOD OF DISPOSITION
1X Burlet 2 Cremetton 3 Removal from State
4 Donation 6 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE ST. JOSEPH' S'acchurch CEM. 9/1/95 POMFRET, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE THORNTON FUNERAL HOME, P.A. MYDIA C. THORNTON JOHNSON MO0583 Great #3439 LIVINGSTON ROAD, POMONKEY, MD. 20640 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Batwean Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in daeth) YULTIPLE STDO AND CUITING WOODS DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE DF): that initiated events reaulting in deeth) LAST 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I, MEDICAL COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 THES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO W UNCERTAIN I PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 28a. DATE OF INJURYS 27.95 28b. TIME OF 27. MANNER OF DEATH 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1500P M 1 YES 2 NO SUNDIOUS TOBBED AM CUS ВУ 2 Accident 281, LOCATION (Street and Number or Rusel Route Number, City or Town, State) 3 Suicide
4 Homicide 8 Could not be COMPLETED datermined CORRECTIONAL FACILITY HOSYLIAND STOPE PURCHATION 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nation end/or investigation. In my opinion, death occurad at the time, date and place, and due to the cause(e) end manner as stated. NATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

O.C.M.E.

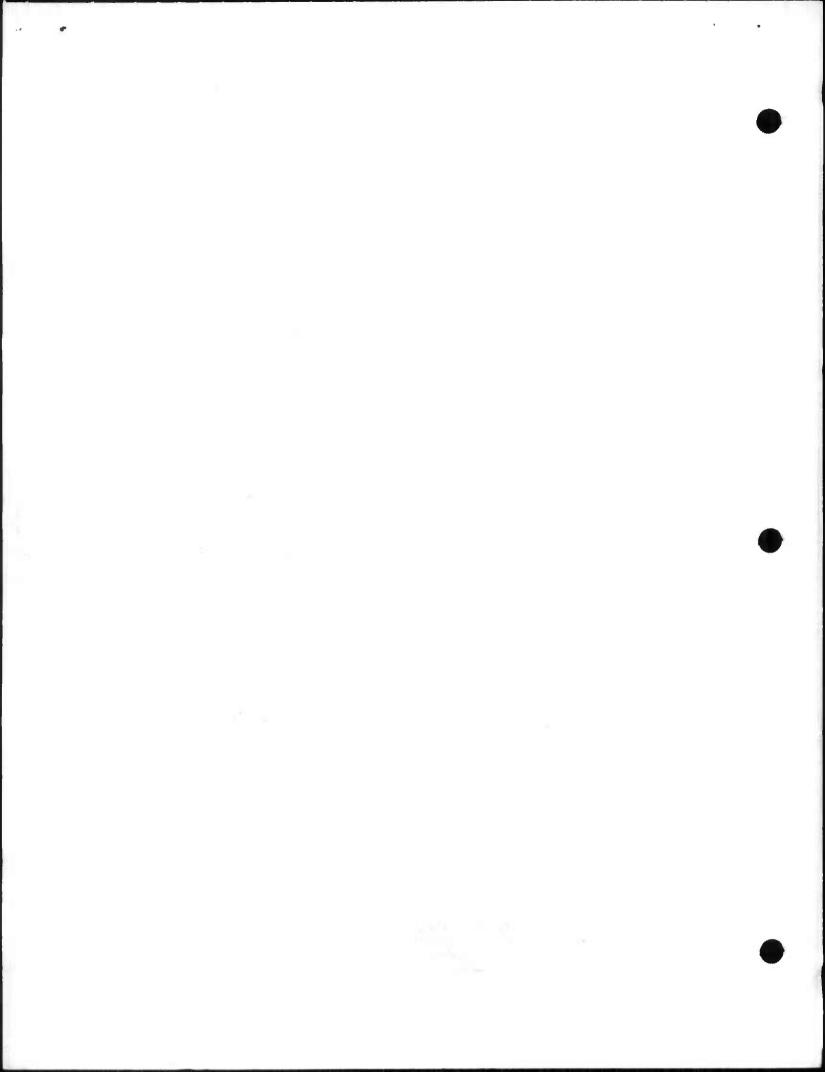
111 Penn Street, Baltimore, Maryland 21201

DHMH-16 Rev 1/89

▶ AUGUST 28 1995

| | or aftend | use as | | |
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| | TO THE HUSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attent | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as | | 9 |
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| - | 25 | JNERA | ithin 7 | NAT: |
| - | 1111 | THE FI | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| 1 | - | H | 2 | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | / DEPARTM | | | MENTAL | HYGIENE REG. NO. | | | | |
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| | | rk Olden Too | | | | 2. DATE O | | 1995 ^{EA} | 3. TIME OF DEATH 3:15 P M | | |
| | 214-12-5939 X | X M 2 D F 71 | M 2 F 71 YRS. MONTHS DAYS HOURS MIN. | | | | | Aug 18, 1924 6. Birthplace (State or Foreign Country Maryland | | | |
| OR | 90. FACILITY NAME (If not institution, give stree Mallard Bay Nurs | EATH | | 9c. COUNTY O | rchester | | | | | | |
| EG | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c, CITY, TO | OWN OR LOCAT | ION | | | | 104 IMPIDE CITY | | |
| DIR | Maryland Dorc | hester | 200 | ldville | | | | 10d. INSIDE CITY LIMITS V 1 YES 2 1 NO | | | |
| ERAL | 100. STREET AND NUMBER 2575 Toddville R | oad | | 1000 | 21672 | | 1 | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| BY FUNERAL DIRECTOR | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. / FORCES? A \(\) YES 2 \(\) IF YES, GIVE WAR OR DATES WW II | OR DATES | | | HISPANIC ORIGIN? (Specify Yes or No | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade cov | TION 16a. I | DECEDENT'S USL | done during mos | N st of working | 16b. / | (IND OF BUSIN | ESS/INDUSTR | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | Water | | | | Seafoo | od | | | |
| SON | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Mi | ddle, Malden Sui | mame) | | | |
| BE (| Wilby O. Todd | | | | | rta l | | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) Helen B. Todd | | 2575 Too | dess (Street at | Rd. To | ddvil | le, Mar | Stete, Zip Code) ryland | 21672 | | |
| | 20a, METHOD OF DISPOSITION 1 Denation 8 Other (Specify) | | Veterar | | | 9/1 | | TION — City or | Town, State Maryland | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICEN | | receidi | 22. NAME AN | D ADDRESS OF FA | CILITY | | | riar y rand | | |
| | I Ash WI to | mes- | | Thoma | s Funera ocust S | al Hon t. Can | ne, P.A nbridge | A. e, Mary | land 21613 | | |
| CERTIFICATION | 23. PARTy. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or reapiratory arrest, about, or heart feliura. List only one cause on asch lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| | PART II. Other aignificent conditions c | | | | cause given in | Part i. 2 | 4a, WAS AN AU | | 4b. WERE AUTOPSY FINDINGS | | |
| PHYSICIAN: MEDICAL | CHF, Algheiner Desease 1 yes 2 70 OF DEATH? OF DEATH? | | | | | | | | COMPLETION OF CAUSE | | |
| AN: | DID TOBACCO USE CONTRIB | | | | UNCERTAI | N.B. | | | | | |
| Sici | | 28. PL/ OSPITAL: Inputient 2 ER/Outputient | | HER: | | | | | | | |
| Ä | 27. MANNER OF DEATH | 28s. DATE OF INJURY | 28b. TIME OF | 28c. INJU | 5 Residence | | Specify) RIBE HOW INJU | JRY OCCURED | | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | M 1 Y | ES 2 NO | | | | 1 | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince Suicince | | | | | | | | e(a) end manner es stated. | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED (Mor | | | | | | | | ED (Month, Day, Year) | | | |
| TO 8 | 20 NAME AND ACCRESS OF STREET | Cannai | | | 21. | 434 | 9 1 | 8/ | 31/95 | | |
| | 20. NAME AND ACCRESS OF PERSON WHO CO | M.D. 15 Frai | nklin | Stree | t Cambr | ridge | , Mar | yland | 21613 | | |
| 31. DATE FILEO MADIN DON NOT 1995 32. DEGISTRAR'S SIGNATURE SEP 1 1995 Julia Diwilliam Randall | | | | | | | | | | | |



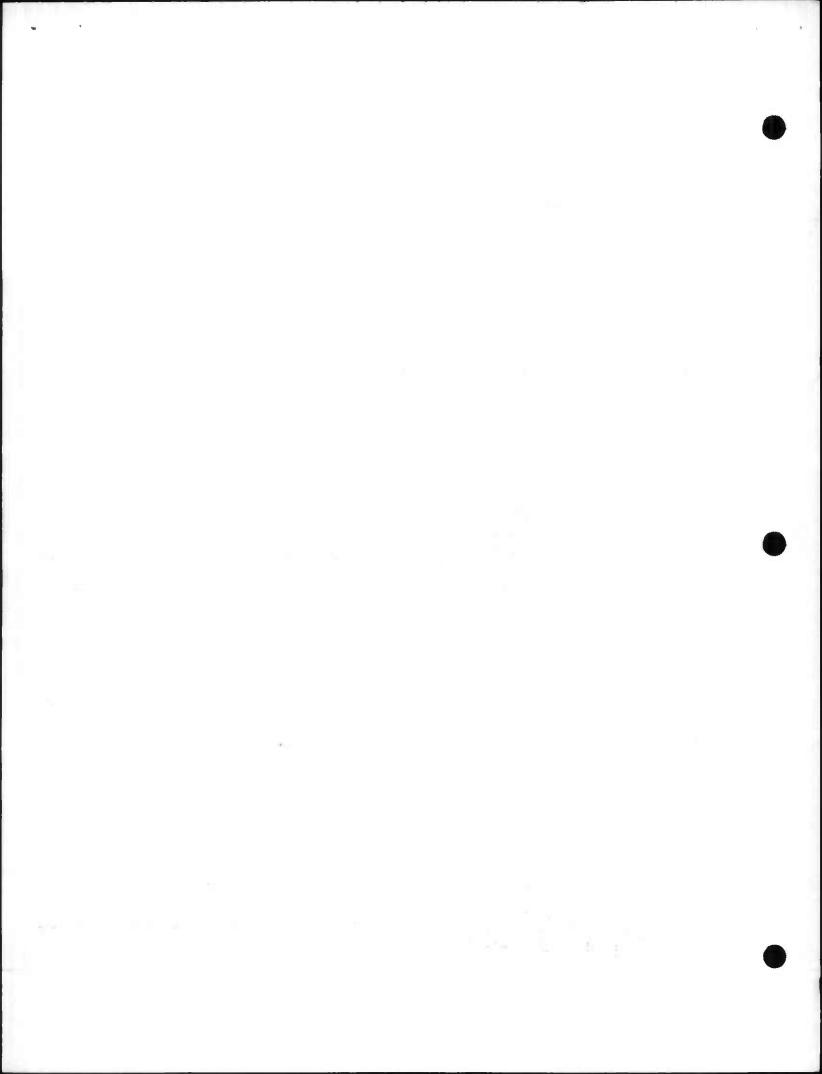
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use as the burial-transit permit, Pages 1, 2, 3 should 24 hours after death. Page 6 may be retained by the hospital or attending physician. page 5 should be detached for notified at once. 9 must director. examiner funeral filled in by the medicai 6 and completely fille burial, cremation. the executed within event, 1 Hygiene prior to burial. traumatic attending physician other 0 the atten Injury, signed by the shows any Dept. of h ME Hem State certificate 6 the marked, With this death OR ATTENDING DIRECTOR: A L hours after d .00 FUNERAL WITHIN 72 H IMPORTANT: 표를 23

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH DAY AUGUST 30 1995 MABEL LOUISE TOBAT 11:15 PM 4 SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Was)
SEPT. 15,1929 5. SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 215-26-5744 65 1 - M 2 AF YRS DELAWARE 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, YOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6140 SUICIDE BRIDGE ROAD EAST NEW MARKET DORCHESTER RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MARYLAND EAST NEW MARKET DORCHESTER 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6140 SUICIDE BRIDGE ROAD 21631 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cuben, Mexican, Puerto Ric 1 YES 2 A NO Specify: BY 3 Widowed 4 Divorced WHITE COMPLETED 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) WATERMAN 12 SEAFOOD 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JAMES HARDING HUTTON STELLA LOUISE HASH BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6136 SUICIDE BRIDGE ROAD, EAST NEW MARKET, MD21631 DEBBIE A. DONOVAN 200 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Description | 2 | Cremation | 3 | Red OUR" LADY OF GOOD COUNSEL 9/4 SECRETARY, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
ZELLER FUNERAL HOME, P. O. BOX 207 Senou 106 MAIN STREET, EAST NEW MARKET, MD 21631 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line. interval Betw **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition_ resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST MEDICAL PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? MAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 | YES 2 | 10 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 6 Could not be 4 Homicide COMPLET 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death red at the time, date and place, and due to the cause(s) and manner as stated. 295 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Modith, Day. 29c. LICENSE NUMBER 2 DEATH (ITEM 27) (Type, Print) 302 Callins Avenue

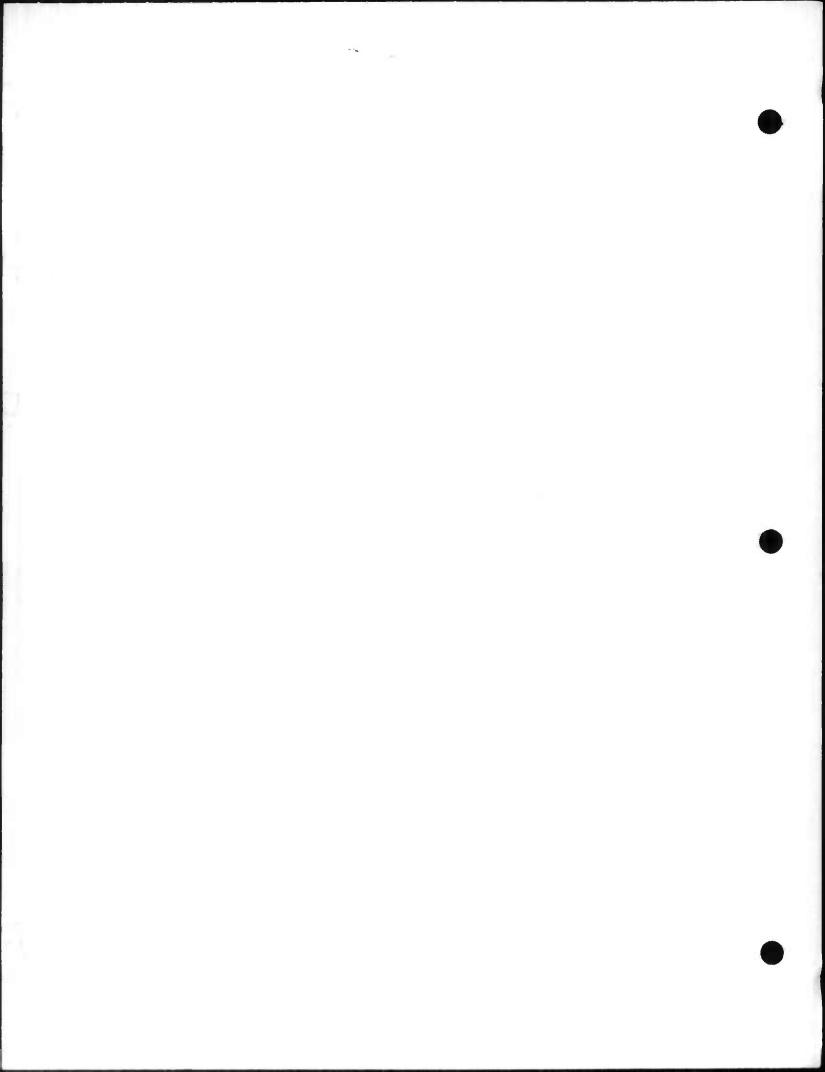
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| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|-----------------------------------------------------|----------|
| R | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPA CERTIF | RTMENT OF I | HEALTH AND | MENTAL | HYGIENI REG. NO. | E | | | | |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------|--------------------|---------------------------------------------------------------------------------|------------------------------|----------------------------------|-----------------------|---------------------------------------------|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | dna UPOLE | | | | 2. DATE OF | F DEATH DA | W y | /EAR S | . TIME OF DE | ATH | _ |
| | 4. SOCIAL SECURITY NUMBER | | | | 7 | | . 3, | 1995 | | 3:30 | р | М |
| | 235-16-3200 | 5. SEX 6. AGE (| (In yrs. lest birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | | Day, Year) | | . BIRTHPI Country) | LACE (State or | Foreign | |
| | 9a. FACILITY NAME (If not institution, give | | , tha. | Sh CITY TOWN | OR LOCATION OF E | | 1 24 | '19 | _ | inth, | WV | _ |
| стов | Garrett County | | oital | 0ak1 | | PEATH | | Garr | | тн | | |
| 쀭 | 10a. STATE 10b. COUNT | TY, TOWN OR LOCA | TION | | | | 1 | od. INSIDE CI | ΓY | _ | | |
| □ | WV Pr | C | orinth | | | | | 1 | LIMITS? | NO | | |
| FUNERAL | P.O. Box 15 | | | 10 | 26713 | | | | S.A. | AT COUNTRY | | |
| E | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EYER IN FORCES? 1 YES | | 13. WAS DEC | CENDENT OF HISPA | NIC DRIGIN? | Specify Yea | or No- 14 | RACE - | - American In | dien, | 7 |
| BY | 3X Widowed 4 Divorced | IF YES, GIVE WAR OR DE | | 1 TYES | NO Speci | ly: | an, etc.) | | | White | | |
| 9 | 15. DECEDENT'S EDU | | 16a, DECEDENT'S | USUAL OCCUPATION | DN | 16h K | IND OF BILE | INESS/INDUS | TRV | | | _ |
| | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of life. Do NOT o | work done during me | ost of working | 100. K | IND OF BUS | MESS/MDUS | INT | | | |
| 기로 | 9th | | Hou | sewife | | | Home | 2 | | | | |
| once. | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | | dle, Meiden S | | | - | | - |
| * | Ball | Lew | | | | inia | | | ight | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | 1 | | G ADDRESS (Street I | | | | | ode) | | | Ī |
| De n | Michael E. Upo | Le | 56 P. | Leasantda | ale Road | , King | wood, | WV | 2653 | 7 | | |
| must | 20a METHOD OF DISPOSITION 1 N Buriel 2 Cremetion 3 Ren | | | DF DISPOSITION (No | | DATE O / F | 20c. LOC | CATION — CH | | , | | 7 |
| | 4 Donation 5 Other (Specify) | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cermetery completely completely County Memorial Gar 9/5 Oakland, MD 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| examiner | Stewart Funeral Home | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | |
| ry, or other traumatic event, the medical | ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| P EH | resulting in death) LAST | | | | | | | | | | | |
| injury. | PART ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | |
| MEDIC | CAI |). | | | | _ ' | PERFORI | MED? | 0 | WAILABLE PRIOR OMPLETION OF F DEATH? YES 2 | R TO CAUSE | |
| N N | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | | | | UNCERTAI | N 🗆 | | | | | | |
| SIC! | EXAMINER? | HOSPITAL: | | TH (Check only one) OTHER: | | | | | | | | 4 |
| 의 수 내 | 27. MANNER OF DEATH | 1 Anpetient 2 ER/Outp | | 4 - Nursing Hom | e 5 🗆 Residence | | | | | | | |
| marked BY Pt | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | 28b. TIR | JURY WO | YES 2 NO | 28d, DESCR | IIBE HOW IN | JURY OCCUP | NED | | | |
| 28 Is | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, | street, lactory, offic | | 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) | | | | | | |
| 튀 로 | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS | ICIAN: To the best of my knowlers: On the bests of examination | ledge, death occur n and/or investigation | ed at the time, date | and place, and due | to the cause | (a) and mand d place, and | ner as stated. I due to the c | ause(a) a | nd manner as | stated. | |
| E C | 29b. SIGNATURE AND TITLE OF CERTIFUE | | | | 29c. LICENSE NU | MBER | | 29d. DATE S | IGNED (M | fonth, Day, Year |) | 4 |
| TO BE CON | 12 | | | | D26568 | | | · 9 | - 3 | -90 | | |
| = | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | | | | - | + |
| | | | | t. Terra | Alta, W | V 2676 | 54 | | | | | |
| | Dr. Roger Lewis, MD 510 W. State St. Terra Alta, WV 26764 31. DATE FILED (Month, Day, Year) SEP 5 1995 July Division Randall | | | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

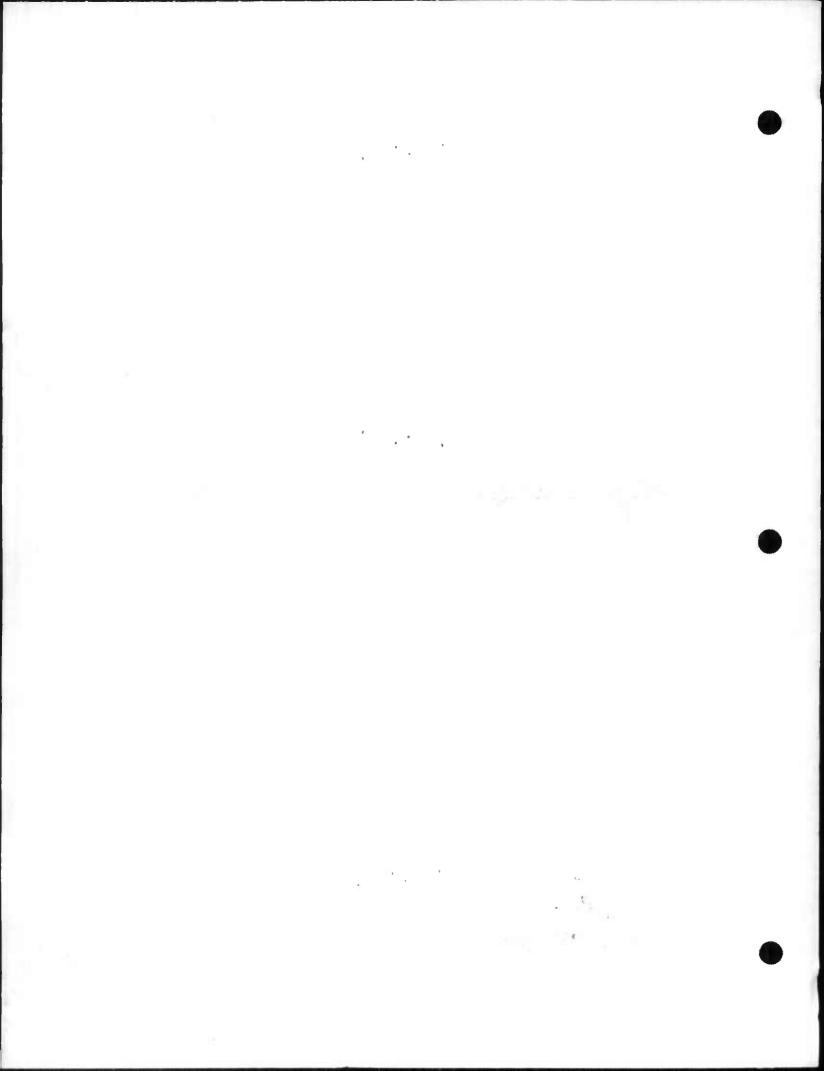
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | MENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | |
|------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------|--|--|--|--|
| 95 | 1. DECEDENT'S NAME (First, Middle, Last) Harriett | Ε. | | Veney | 2. DATE OF DEATH AUGUST 22, 1995 | YEAR 3. TIME OF DEATH 11:05 A M | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | MC MC | FUNDER 1 YEAR IF UNDER 24 HRS. INTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | | | | |
| - 8 | 220-09-4442 9e. FACILITY NAME (If not institution, give s | | 78 'YAS. | b. CITY, TOWN OR LOCATION OF | 6-9-1917 OEATH Jac CI | Virginia DUNTY OF GEATH | | | | |
| TOR | Physicians Memorial H | ospital | | La Plata | | parles | | | | |
| DIRECTOR | 10s. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCATION | | 10d. INSIDE CITY | | | | |
| L DI | Maryland Charl | .es | La Pi | lata 101, ZIP CODE | | 1 TES 2 NO | | | | |
| FUNERAL | 136 Kalmia Ct. La | aPlate,Md. | | 20646 | | J.S.A | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT EVER II FORCES? 1 YES | 2 NO | | ANIC ORIGIN? (Specify Yes or No- | | | | | |
| Э ВУ | 3 🕅 Widowed 4 🗌 Divorced | IF YES, GIVE WAR OR D | PATES | 1 TYES 2 NO Spec | | Specify: Black | | | | |
| COMPLETED | 15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | completed) | 16a. OECEDENT'S US (Give kind of work life. Do NOT use re | UAL OCCUPATION done during most of working stired.) | 16b. KIND OF BUSINESS/ | | | | | |
| MPL | 7th. | College (1-4 or 5+) | | okina | Restaurant | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | 16. MOTHER'S N | IAME (First, Middle, Meiden Surneme |) | | | | |
| BE (| Baylor Phillips 19a, INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | Annie | Veney If Route Number, City or Town, State, | Zin Coriel | | | | |
| ٩ | Venessa Goldri | ing | | | ata,Maryland 20 | | | | | |
| | 20s. METHOD OF DISPOSITION 1 ☒ Burlel 2 ☐ Cremation 3 ☐ Rem- | oval from State 20b | PLACE AND DATE OF D | olace) Church Cemetery | DATES 20c. LOCATION | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | incily papt. | | 8/26/ Farnham, | Virginia 2246U | | | | |
| 3 | Eugene | W. Lee 1 | 0000 63 | Lee Lyngaal | Hamo In the | ng Heage Val | | | | |
| | 23. PART I. Effor the diseases, or o | complications that caused List only one cause on e | d the deeth. Do not each line. | enter the mode of dying, su | ch as cardiac or respiratory | arrest, Approximeta Interval Between | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | |
| | resulting in death) | DUE TO (OR AS A | A CONSEQUENCE OF): | 7 -10-1 | THICKIE E | ONE WEEK. | | | | |
| NOI | Sequentially list conditions, if any, leading to immediate | FEW WEEKS | | | | | | | | |
| ICAT | cause. Enter UNDERLYING CAUSE (Disease or Injury | 6 | | ABCCESS | | FEW WEEKS | | | | |
| CERTIFICATION | thet initiated events resulting in deeth) LAST | | NEMIA | | | FEW HONTHS | | | | |
| | PART II. Other algolificant condition | s contributing to death b | out not resulting in t | he underlying cause given is | n Part I. 24s. WAS AN AUTOPS | | | | | |
| DICAL | SIP. | WHIPPL | | CEDURE | PERFORMED? | Y 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| PHYSICIAN: MEDIC | DID TORACCO LISE CONTI | DIBLITE TO CALLER O | E DEATH VEC | | | 1 YES 2 NO | | | | |
| IAN | DID TOBACCO USE CONTI | | 26. PLACE OF DEATH (| | IN LI | | | | | |
| YSIC | 1 TYES 2 NO | HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outp | patient 3 DOA 4 | THER: Nursing Home 5 - Residence | 6 Other (Specify) | | | | | |
| Y PH | 27. MANNER OF DEATH 1 Herural 5 Pending 2 Accident Investigation | (Month, Day, Year) | 29b. TIME O | | 28d. DESCRIBE HOW INJURY O | OCCURED | | | | |
| D BY | 3 Suicide 8 Could not be | 26e. PLACE OF INJURY building, etc. (Spec | — At home, term, stree | | 281. LOCATION (Street and Numl City or Yown, Stele) | per or Rural Route Number, | | | | |
| | | | | | | | | | | |
| COMPLETED | (Check only | CIAN: To the best of my knowledge. On the beste of examination | ledge, death occurred a n and/or investigation, is | t the time, date end place, end du n my opinion, death occured at th | e to the cause(e) end menner ee a | tated. The ceuse(s) end manner ee stated. | | | | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NL | | ATE SIGNED (Month, Day, Year) | | | | |
| 0 | 38. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF OF | ATH (ITEM 27) Gran By | | • | 8/2/95 | | | | |
| | Niran Sharma MD,11345 | Pembrooke Sa. S | Suite 104 Wal | | | | | | | |
| | 31. DATE FILED (Month, Dey, Year) SEP 0 8 1995 | 37. REGISTRAR'S SIGN. | ATUDE ATUDE | <u> </u> | | | | | | |
| | SEP 0 0 1333 | Dane ar arranger | - 04/104 | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

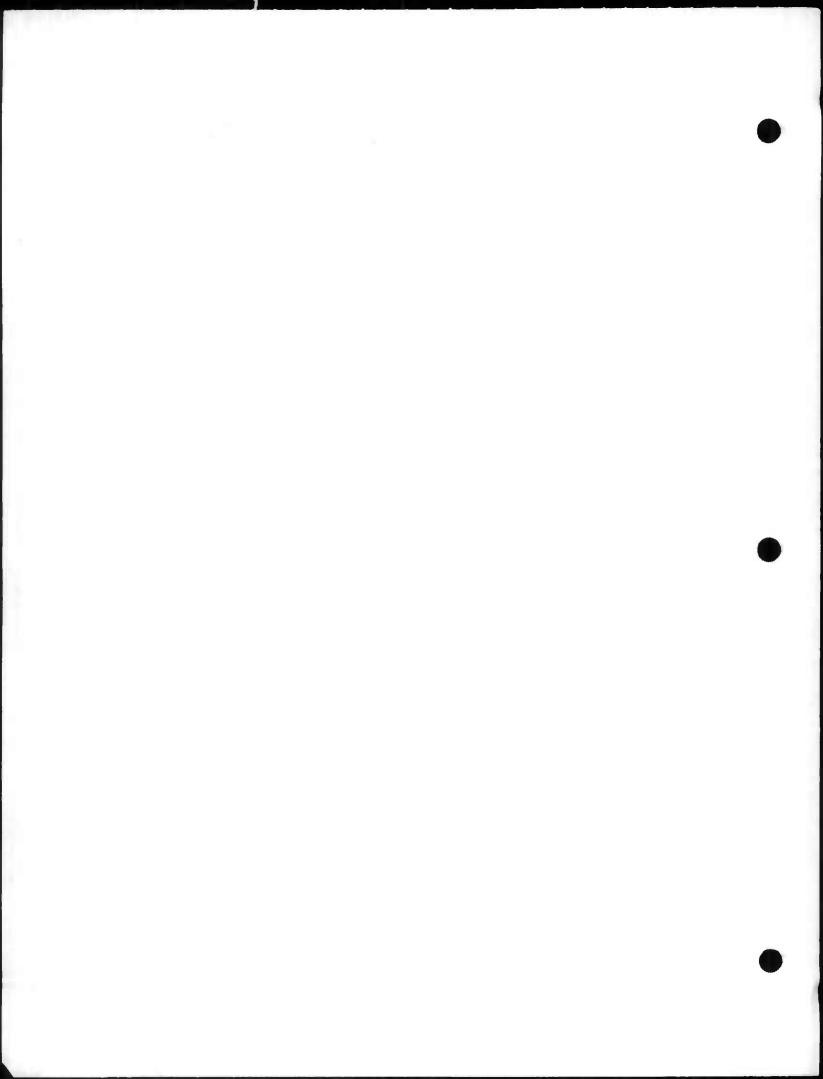
DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any found related by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

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| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAND | DEPARTM | ENT OF H | EALTH A | AND ME | NTAL HYGIEN | E | | | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------|---------------------|-----------------------|---------------------------|---------------------------------------------------------------------------------|---------------|-----------------|---------------------------------|----------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Wright | | | | 2. DATE OF DEATH | | | TIME OF DEA | | |
| | William 4. SOCIAL SECURITY NUMBER 5, SE | William Leslie RHTY NUMBER 5. SEX 6. AGE (In yrs. In | | | | | Aug. 14 | | | 2:07 | a _M |
| 7 | The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa | M 2 🗆 F 82 | MON | THE DAYS | HOURS | MIN | (Month, Day, Year) | | Country) Mary | ACE (State or F | oreign |
| _ | 9a. FACILITY NAME (If not institution, give street and | 9b. | CITY, TOWN C | R LOCATION | | | | UNTY OF DEATH | | | |
| FUNERAL DIRECTOR | Memorial Hospital | | | East | on | | | Ta1 | bot | | |
| REC | 10e. STATE 10b. COUNTY | 10c. CITY, TO | WN OR LOCAT | ION | | | | 16 | Od. INSIDE CITY | 1 | |
| 0 | Maryland Caroline | Dent | | | | | | | YES 2 X | NO | |
| RA | 9551 Tuckahoe Road | | 101 | 2162 | 20 | 10g. CITIZEN OF WHAT COUN | | | AT COUNTRY? | | |
| S | 11. MARITAL STATUS 12, WA | AS DECEDENT EVER IN U.S. AF | RMED | 13. WAS DEC | ENDENT OF | HISPANIC (| ORIGIN? (Specify Yes | | - | - American Indi Vhita, afc. | en, |
| BYF | | ORCES? 1 TYES 2 XX YES, GIVE WAR OR DATES | ND | | cify Cuben, 2 X NO | | uerto Rican, etc.) | | Specify: | | |
| | 15. DECEDENT'S EDUCATION | 18a. Di | ECEDENT'S USUA | AL OCCUPATIO | IN . | | 16b. KIND OF BUS | _ | auca | sian | |
| COMPLETED | | | Give kind of work on Do NOT use reti | red.) | st of working | | | | | | |
| MP | 17. FATHER'S NAME (First, Middle, Lest) | Farming | | | | Farm | | | | | |
| | | on Wright | | | | | (First, Middle, Meiden Lois 1 | Sumame) | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | b. MAILING AOD | RESS (Street a | | | Number, City or Town | | Code) | | | |
| 2 | Elizabeth Comegys | | 214 Wal | nut St | reet, | Chu | rch Hill, | Mary | 1and | 2162 | 3 |
| - 1 | 20s. METHOD OF DISPOSITION [X] Burlel 2 Cremation 3 Removal from 4 Donation 6 Other (Specify) | m State cemetery, cre | AND DATE OF DIS | lace) | me of | 1 | | CATION — CI | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | I Dent | on Ceme | tery 22. NAME AN | D ADDRESS | | | iton, | Mary | land | |
| | 1 - Garlan | Minne | | Moor | re Fu | neral | Home, P | .A. | 3 0 | 1.600 | |
| | 23. PART I. Enter the diseases, or complic | cations that caused the de | eeth. Do not e | nter the mo | de of dylng | g, auch e | Denton, | ratory arre | allia Z | Approxim | ata |
| | shock, or heart fallure. List on IMMEDIATE CAUSE (Final | ny one cause on each line | | | | | | | | Onset and | |
| | disease or condition resulting in death) a. 205/5 | | | | | | | | res | | |
| z | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| TIO | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| FICA | CAUSE (Disease or injury the Initiated events Due to (DR 45 A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | |
| AL CE | PART II. Other algnificent conditions contr | ributing to death but not | reaulting in the | e underivino | ceuse div | en in Par | t I. 24a, WAS AN | ALITTORY | 7.4h W | ERE AUTOPSY F | MUNICO |
| | Enjhoon2 | Com | | o unactiying | , course give | , oii vii v ai | PERFOR | MED? | AV CC | MILABLE PRIOR OMPLETION OF (| TO |
| MEDIC | | | | | | | . 1 125 2 | Mun | | F DEATH? | NO |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | |
| PHYSICIAN: | | PITAL: | | HER: | | C=21 111 | | | | | |
| HYS | | patient 2 ER/Outpatient 3 6e. DATE OF INJURY | 26b. TIME OF | 28c, INJU | JRY AT | | Other (Specify) d. DESCRIBE HOW II | JURY OCCU | RED | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | M 1 TY | | | | | | | |
| 8 | | 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At hom building, atc. (Specify) | | | | 28 | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| LET | OA OFFICIER V | | | | | | | | | | |
| COMPLET | (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dats and place, and dus to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dats and place, and dus to the cause(s) and menner as stated. | | | | | | | | | | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | () 40 | | 1 | 29c. LICEN | | | | | onth _j Day, Year) | |
| TO B | 2/1706 | 410000 | X / | M | D | 465 | 520 | 1.8 | 114 | 195 | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMP | | | | | | | | | | |
| | Jennifer Hollywood, | M.D., 607 DI | Ounda 200 | 's Lan | e. Ea | ston | Marylar | d 216 | 01 | | |
| AUG TO 30 | | | | | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the feath. Page 6 may be retained by the hospital or attending physician.

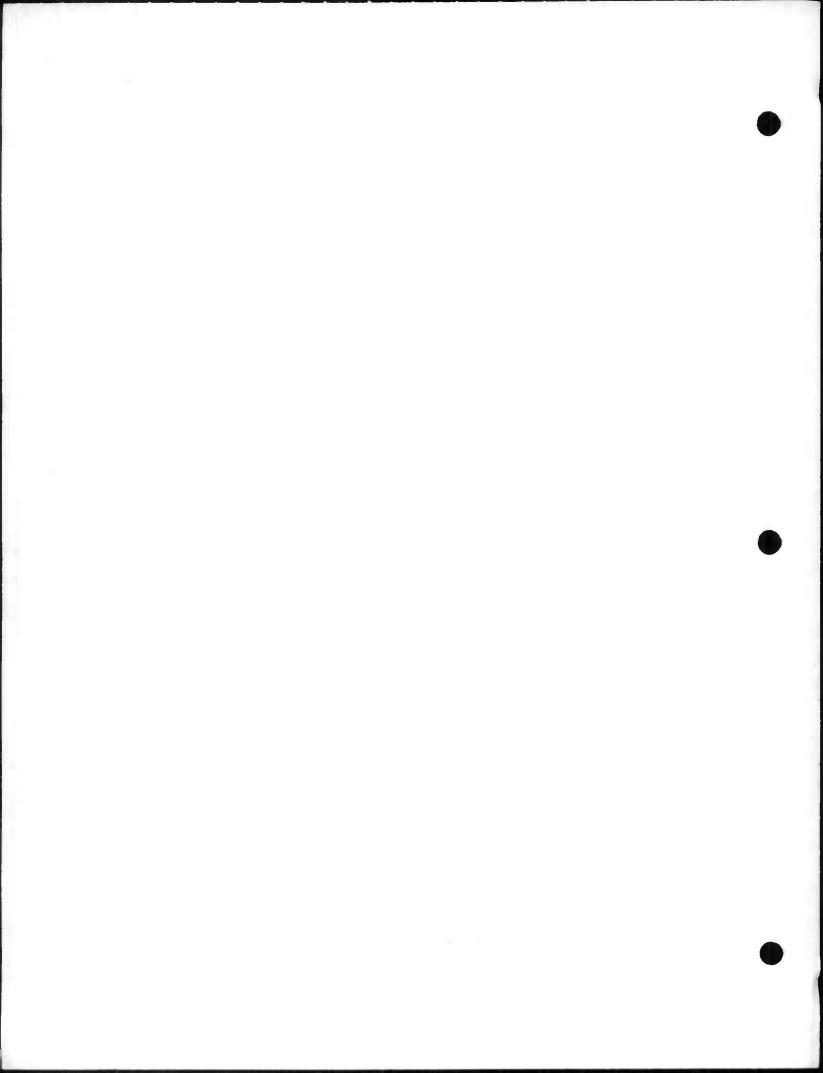
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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| , | REGISTRAR | | CERTI | FICATE OF | DEATH | REG. NO |), | | | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------|---------------------|--------------------------------------------|--|--|
| 1 3 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| 100 | Corn | elius E | Cllsworth | Whit | ing | August 1 | 7 1995 YEA | 8:00 A | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthda | | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | RTHPLACE (State or Foreign | | |
| | 213-22-8539 | 1 및 M 2 □ F | | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | Co | untry) | | |
| | | 4.5 | 82 YRS | | | August 16, 1 | | rginia | | |
| 000 | De. FACILITY NAME (If not institution, give | | | 9b. CITY, TOWN | OR LOCATION OF DE | EATH | 9c. COUNTY OF | FDEATH | | |
| Ö | Memorial Hospita | 1 | | East | n | | Та | 1bot | | |
| <u>[</u> | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | TV. | | | | | 1 10 | | | |
| DIRECTOR | | | 10c. C | ITY, TOWN OR LOCA | ITION | | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland Tal | bot | | Newtown, | near Co | rdova | | 1 YES 2 NO | | |
| ₹ | 10e. STREET AND NUMBER | | | | H. ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | | |
| 1 15 | 13027 Newtown Village Road 21625 U.S.A. | | | | | | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | EVER IN U.S. ARMED | 13. WAS DE | | NIC ORIGIN? (Specify Ye | | | | |
| | 1 Never Married 2 Merried | FORCES? 1 | YES 2 NO | NO If yes, specify Cuban, Maxican, I | | | Bi | ACE — American Indian, ack, White, etc. | | |
| B | 3 Widowed 4 Divorced | | ALL OFF DATES | 1016 | S 22 E NO Specin | γ: | | ecily: ack | | |
| 8 | 15. DECEDENT'S EDU | CATION | 18a. DECEDENT | S USUAL OCCUPAT | ON | 165 KIND OF BU | SINESS/INDUSTRY | | | |
| | (Specify only highest gradi | | (Give kind o | f work done during m use retired.) | ost of working | | | | | |
| 4 | 12 | College (1-4 or 5+ | · . | | | _ | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | C | rpenter | | | struction | on | | |
| | | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | | | |
| BE | Unknown | | | | <u> </u> | Unknown | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILII | IG ADDRESS (Street | and Number or Rural F | Route Number, City or Tow | m, State, Zip Code) | | | |
| | Rose M. Whiting | | PO I | 30x 26, W | ye Mills | , Maryland | 21679 | | | |
| | 20a, METNOD OF DISPOSITION | and from Cont. | 20b. PLACE AND DAT | E OF DISPOSITION (N | | DATE 20c. LO | CATION — City or | Town, State | | |
| | 4 Donation 5 Other (Specify) | | Newtown (| | | 8/23 Ne | wtown | va, Maryland | | |
| 1 3 | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 7 | | ND ADDRESS OF FA | CILITY | r cordo | va, Maryland | | |
| | 1 | 101 | n. | Moor | e Funera | 1 Home, P. | Α. | | | |
| | - James | 24/1 | 60 re | → PO D | rawer B. | Denton, M | arvland | 21629 | | |
| | 23. PART I. Enter the diseases/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallers. List only one cause on each line. | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | List only one ceu | se on each line. | \ | | | | Interval Between Onset and Death | | |
| | disease or condition | 1 | 111000 | 1 | 0 — | 1 | | Onset and Daath | | |
| | resulting in death) | B. DUE TO | OR AS A CONSEQUENCE | aias 1 | wear | Mon | | 10-15 MILLS | | |
| | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, | | | | | | | | | |
| A | if any, leading to immediate | cause. Enter UNDERLYING | | | | | | | | |
| 일 | CAUSE (Disease or Injury | C. DUE TO | OR AS A CONSEQUENCE | | | | | | | |
| Ē | that initieted events resulting in death) LAST | 502 10 (| ON AS A CONSCOUENCE | OF): | | | | i | | |
| 5 | | d | | | | | | | | |
| | PART II. Other algnificant condition | na contributing to | deeth but not resulting | In the underlyin | a ceuse alven in | Part I. 24s. WAS AN | Airmany | 4b. WERE AUTOPSY FINDINGS | | |
| EDICAL | | | | , ar the directly in | g couse given in | PERFOR | MEDS. | AVAILABLE PRIOR TO | | |
| 0 | | | | | | 1 🗆 YES 2 | 100 | COMPLETION OF CAUSE OF DEATH? | | |
| × | | | | | | _ | | 1 TES 2 NO | | |
| ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | |
| 🕺 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | THE REAL PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPE | | | | | | | | |
| Sic | 1 TES 2 NO | HOSPITAL: | ER/Outpatient 3 DOA | OTHER: | ne 5 🗆 Residence | 8 Other (Specific) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF | NJURY 28b. T | ME OF 28c. IN. | JURY AT | 28d. DESCRIBE HOW I | NJURY OCCURED | | | |
| | 1 Natural 5 Pending | (Month, Da | | JURY W | YES 2 NO | ZOG. DEGONDE NOW I | NSBNY OCCORED | | | |
| В | Accident Investigation | 28a PLACE OF | INJURY — At home, farm | | | | | | | |
| 8 | 3 Suicide 8 Could not be 4 Homicide delermined | building, | Mc. (Specify) | , street, factory, offic | ctory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | | | | | | | | | | |
| 김 | 29a. CERTIFUM CERTIFUNG PHYS | ICIAN: To the best of | and place, end due | to the cause(a) and man | nner ea stated. | | | | | |
| COMPLET | | | | e(a) end manner ea stated. | | | | | | |
| | 286. MENATURE AND JITLE OF CERTIFIE | ni kanak | | | | | | | | |
| BE | | (3X) | n. | (1) | 29c. LICENSE NUM | I A C | 29d. DATE SIGN | EO (Month, Day, Year) | | |
| 9 | 1 menre D | . \ / OV | | | 0 46 | TOY | 2. | 11.70 | | |
| | | | E DE DEATH (ITEM 97) /T. | e. Print) | | | | | | |
| 80 | 30. NAME AND ADDRESS OF PERSON WE | IO COMPLETEO CAUS | L OF DEATH (ITEM 27) (19) | | | • | | | | |
| 100 | Lawrence Bohan, | | | | aston. Ma | rvland 2 | 1601 | | | |
| (8) | | M.D. 606 | Dutchmen's | | aston, Ma | ryland 2 | 1601 | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Comendat #7, 8/22/95, MRS, allegany Co.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | * REGISTRAR | | CE | RTIF | ICATE O | DEATH | | REG. NO |) | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------|-----------------------------------------|-----------------|-------------------------|--------------------------------------------------------|--------------|--------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | |
| | HERMAN ELL | SWORTH | WRIGH | т | | | AUGI | | 7 . | 1995 | 2:20 P M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (in yrs. less | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | ., | 8. BIRTH | IPLACE (State or Foreign | |
| î | 214 36 6496 | 1 🔀 M 2 🗆 F | 57 | YRS. | MONTHS DAYS | HOURS MIN. | SEPT | 33, | 1937 | MAR | YLAND | |
| | 9a. FACILITY NAME (If not institution, give st | treet and number) | | | 9b. CITY, TOWN | OR LOCATION OF D | | | - | DUNTY OF D | | |
| OR | SACRED HEART HOSE | PITAL | | | CUM | BERLAND | | | ALI | LEGANY | 7 | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | ALIGHNY . | |
| DIRECTOR | | | | | Y, TOWN OR LOC | | | | | | 10d. INSIDE CITY LIMITS? | |
| | MARYLAND ALLEC | JAN I | | | FROSTBI | | | | 7 | | 1 YES 2 X NO | |
| RA | | TC 377 | | | | Of. ZIP CODE | | | | | WHAT COUNTRY? | |
| FUNERAL | 10136 COTTAGE LAN | | T EVER IN U.S. ARI | 450 | | 21532 | | | | J.S.A. | | |
| | 1 Never Married 2 Married | FORCES? 1 | YES ZYN | 0 | If yea, i | CENDENT OF HISPA pecify Cuban, Maxic | en, Puerto Rice | specify Ye in, etc.) | s or No- | Black | — American Indian, c, White, atc. | |
| B | 3 Widowed 4 Divorced | IF TES, GIVE W | INH OH DATES | | 1 [] YI | S 2 XND Speci | lly: | | | Speci | WHITE | |
| COMPLETED | 15. DECEOENT'S EDUC (Specify only highest grade | CATION | 16a. DEC | CEDENT'S | USUAL OCCUPAT | TON | 16b. KI | ND OF BU | SINESS/ | NDUSTRY | | |
| Ē | Elementary/Secondary (0-12) | College (1-4 or 5 + | Man | Do NOT us | vork done during r e retired.) | tosi of working | | | | | | |
| MP | 11 | | TH | RUCK | DRIVER | | | CONC | RETE | Ξ | | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | ME (First, Mide | lle, Maider | Sumame |) | | |
| BE | GEORGE A. WRIGHT | 3 | | | | MARTHA | E. ST | EELE | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | and Number or Rural | | | | , | | |
| | PATRICIA WRIGHT | | 10 |)136 | COTTAGE | LANE, N | W, FRO | STBU | RG, | MD 21 | .532 | |
| | 20e. METHOD OF DISPOSITION 1 ↑ Burlal 2 □ Cremation 3 □ Rame | rvsi from State | 20b. PLACE A cemetery, cres | ND DATE O | F DISPOSITION (| leme of | OATE | 20c. LC | CATION | — City or To | wn, Stata | |
| | 4 1 Donation 5 □ Other (Specify) 21. SEGMATURE OF PERSONAL SERVICEPLICE | | ECKHA | ART C | EMETERY | , AUG 20 | ,1995 | ECK | HART | , MD | | |
| | A SHORE OF FORMAL SERVICE | JA. | 1 | | 22. NAME | AND ADDRESS OF FA | ICILITY | | | | | |
| | * 7/1/milou | /// | X-Ouk | 10 | | MAIN ST | | | | MD 21 | 532 | |
| | 23. PART 1. Enter the diseases, of c shock, or haert fellure. I | List only one cau | se on each line. | | ot enter the m | ode of dying, aud | ch as cardiad | or reap | Iratory | arrest, | Approximeta Interval Between | |
| | disease or condition resulting in death) | IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Cann nomit that Mening in the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition | | | | | | | | | | |
| | DUE TO THE AS A CONSEQUENCE OF): | | | | | | | | | | | |
| z l | Securation let conditions | . /// | alig | na | n/ | xym | WASI | ma | | | 5 morgh | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | DUE TO | (DD 40 4 0011000 | DR AS A CONSEQUENCE OF): | | | | | | | | |
| Ē | that initiated eventa DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | | |
| | d | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying care | | | | | | Part I. 24 | a. WAS AN | | Y 24b. | WERE AUTOPSY FINDINGS | |
| DICAL | Marin | | - 1 | | _ , | PERFORMED? | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHS | | | |
| | Conflictive Atlant Majlane | | | | | | | | 1 VES 2 NO | | | |
| ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DO UNCERTAIN | | | | | | | | | | | |
| SIA | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) | | | | | | | | | | | |
| YSI | 1 - YES 2 1 40 | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: 4 Nursing Ho | me 5 - Raaldence | 6 Other (S | pecify) | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) 26. PLACE OF OEATH (Check only one) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28d. DATE OF INJURY WORK? 28d. DESCRIBE HOW | | | | | | | BE HOW | NJURY C | CCURED | | | |
| B | 2 Accident Investigation 3 Suicide 8 Could not be | M 1 YES 2 NO | | | | | | | | | | |
| TED | 4 Homicide 8 Could not be detarmined | , 101111, p | rm, street, factory, offica 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) | | | | oute Number, | | | | | |
| P. | 20a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Do the best of my knowledge, death occurred at the time, data and place, and due to the care one) 2 MEDICAL EXAMINER: Do the best of axamination-end/or investigation, in my opinion, death occurred at the time, data | | | | | | | | | | | and manner as stated. | |
| | 296. SHENARTHE AND TITLE OF EMPTHER | 1111- | 1 | _ | | 29c. LICENSE NUI | MBER | | 29d, D | ATE SIGNEO | (Month, Day, Year) | |
| TO BE | Change (14) | jun | 11 | M | 0 | 029 | 195 | -/ | • | AUGUS | .0 01 | |
| - | 30. HAME AND ADDITIESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITEM | 27) (Туре, | Print) | | | | | 1 . | | |
| CHANG HOH, MO GOTAGN TERRACE, MROSTBURG, MODIS | | | | | | | (2) | | | | | |
| | CHILLY LICH | 1/11/0) | 10 (MK | 10 / | CLUMCO | -/// | 15/6/41 | 17. | Ma | 04 | 220 | |
| | TI. DATE FILED (Month, Day, Year) | 12. REGISTRA | HIS SIGNATURE | date | CHEC | - / //KC | 15(16)41 | 9. | mo | 04 | 229 | |

100-1-12

DIVISION OF VITAL RECORDS, P.O. BOX 68760

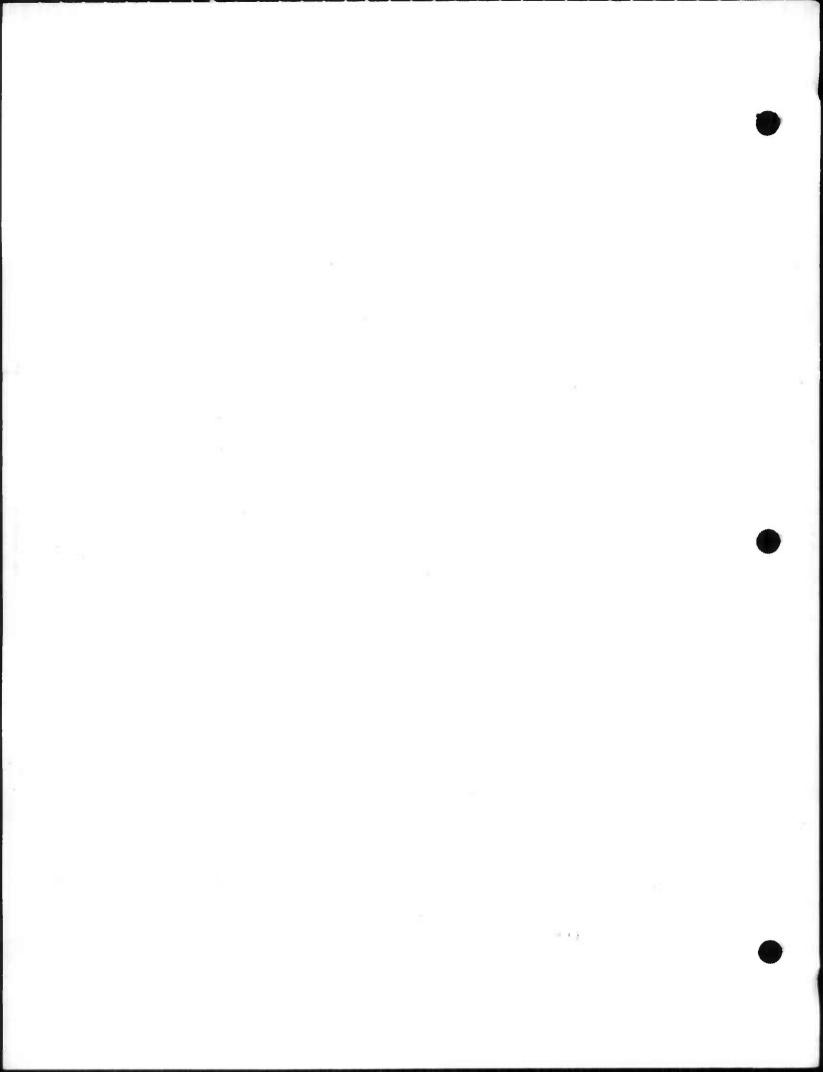
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | | CATE OF DEATH | REG. NO. | | | | | | |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------|--|--|--|--|--|
| - 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATN | 3. TIME OF DEATN | | | | | |
| | FRANK DENSMOR | E WINTER | RS | AUGUST 14 19 | YEAR | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 0 | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | Sept. 21, 1914 | a. BIRTHPLACE (State or Foreign Country) Mary Land | | | | | |
| | 9e. FACILITY NAME (If not institution, give street end number | | 96. CITY, TOWN OR LOCATION OF D | | OUNTY OF DEATH | | | | | |
| TOR | Sacred Heart Hospital | | Cumberland | A11 | Legany | | | | | |
| E | 10a. STATE 10b. COUNTY | | TOWN OR LOCATION | | 10d, INSIDE CITY LIMITS? | | | | | |
| <u>a</u> | Maryland Allegany | Frost | burg | | 1 YES 2X NO | | | | | |
| FUNERAL DIRECTOR | 15330 Miners Avenue | | 101. ZIP CODE 21532 | 10g. CI USA | ITIZEN OF WHAT COUNTRY? | | | | | |
| BY FUN | 1 Never Married 2 V Married FORCES? | DENT EVER IN U.S. ARMED 1 YES 2 NO VE WAR OR DATES | 13. WAS DECENDENT OF NISPA If yes, specify Cuban, Mexic 1 YES 2 NO Specif | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S I | USUAL OCCUPATION | 16b. KIND OF BUSINESS/II | NDUSTRY | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 c | (GIVE KING OF W He. Do NOT use | ork done during most of working retired.) | Coal | | | | | | |
| MP | 12 | 0 Mine | r | Coal | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Lest) | | | ME (First, Middle, Meiden Surneme) | | | | | | |
| BE | James Winters 190. INFORMANT'S NAME (Type/Print) | | Elizab | | | | | | | |
| 2 | Pearl Winters | 15330 | ADDRESS (Street and Number or Rural Miners Avenue, F | rostburg, Md. 2 | 1532 | | | | | |
| | 20e. METHOD OF DISPOSITION 1 XBurlel 2 Cremetion 3 Removal from State | 20b. PLACE AND DATE Of cemetery, crematory or off | and office of | | - City or Town, State | | | | | |
| | 4 Donation 5 Other (Specify) | Mountain Vi | ew Cemetery Aug | .17,1995 Mosco | w Mills, Md. | | | | | |
| | Days S. Milk | | | enzie Funeral | Home | | | | | |
| | 23. Part i. Enter the diseases, or complications | that caused the death. Do no | Lonaconing Mo | h se cardiec or respiratory a | rrest, Approximate | | | | | |
| | shock, or heart failure. List only one iMMEDIATE CAUSE (Fine) | csuse on each line. | | , | Interval Between Onset and Death | | | | | |
| | disease or condition resulting in death) a. ACUTE RESPIRATORY FAIL URE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | DUE | TO (OR AS A CONSEQUENCE OF | 110/0/ | LUME | en way | | | | | |
| Z | CHR | NICLUNG | DISEASE | | Ten years | | | | | |
| CERTIFICATION | Sequentisity list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Ten yes | | | | | | | | | |
| 5 | CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or injury CAUSE (Disease or inj | | | | | | | | | |
| Ē | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | |
| E I | d | | | | | | | | | |
| | PART II. Other significant conditions contributing | to deeth but not resulting in | the underlying ceuse given in | Part i. 24s. WAS AN AUTOPS' | 24b. WERE AUTOPSY FINDINGS | | | | | |
| EDICAL | ANGINA, CARCIN | JMA OF LUA | IG. ANEMIA | 1 TYES 2 NO | COMPLETION OF CAUSE OF DEATH? | | | | | |
| E E | CANCEROFLIVE | | | _ | 1 YES 2 NO | | | | | |
| ÿ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑ | | | | | | | | | |
| 호 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | (Check only one) OTHER: | | | | | | | |
| PHYSICIAN: | | 2 ER/Outpatient 3 DOA | 4 - Nursing Home 5 - Residence | | | | | | | |
| BY PH | | E OF INJURY 26b. TIME INJU | OF 26c, INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HOW INJURY O | CCURED | | | | | |
| | 3 Suicide a Could not be 26e. PLAC | CE OF INJURY — At home, farm, st lng, etc. (Specify) | reet, fectory, office | 261. LOCATION (Street and Numb City or Town, Stete) | er or Rural Route Number, | | | | | |
| | 29e. CERTIFIER | | | | | | | | | |
| COMPLETE | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. One) MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. | | | | | | | | | |
| | 29). SIGNATIBE AND TITLE OF PEDTICING | | | | | | | | | |
| B | welly S. Hijal N | 290. SIGNATURE AND TITLE OF CERTIFIER 290. LICENSE NUMBER 290. DATE SIGNED (Morith, Day, Your) P11 925 AUGUST 14, 1995 | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W'S'HIJAB, MD 909-A SETON DR. CUMBERLAND, MO 21502 | | | | | | | | | |
| TO. | W. S. HIJAB, MD | 709-A SETON | DR. CUMSE | RLANDIM | 021500 | | | | | |



BALTIMORE, MARYLAND 21215-0020 HOSPITAL OR ATTENDIN TO THE HOSPITAL OF TO THE FUNERAL OF See filed within 72 ho

| | iges 1, 2, 3 should | |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| mysician. | urlal-transit permit. Pa | |
| arrending | use as the t | |
| re nospital or | letached for | nce. |
| etained by tr | should be | lic event, the medical examiner must be notified at once. |
| o may be | ctor, page 5 | must be n |
| am. rage | ineral dire | aminer I |
| ours arrer on | in by the firremoval. | nedical ex |
| 1 24 DC | tely filled mation, o | t, the n |
| ecuted wit | 0 = | atic even |
| icate be ex | er this certificate has been signed by the attending physician and coth with the State Dept. of Health and Mental Hygiene prior to buria | 23 shows any injury, or other traumatic |
| leath certif | attending ntal Hygier | y, or oth |
| hat the c | d by the | my infu |
| requires t | s been signed by the attending | shows a |
| The law ri | ate has b | E |
| 4G PHYSICIAN: | is certific ith the S | ed, or i |
| MDING PH | : After th | is mark |
| DR ATTE | DIRECTOR | item 28 |
| HOSPITAL OR ATTENDING | E FUNERAL DIRECTOR: After this certificate dwithin 72 hours after death with the State | RTANT: If item 28 is marked, or i |
| ш | LU TO | Name . |

27500 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 AUGUST 26. 1:44 KEVIN WELLS AM 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH (Month, Day, Year) 08-10-1948 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SE) 220-78-1303 27 DAYS 1 X M 2 - F 9c. COUNTY OF DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10c. ONLY, TOWN OR LOCATION 10a, STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? MD Omeiset 1 YES 2 NO Vinces FUNERAL 10a. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 101 ZIP CODE 30450 21853 2 HAMPDEN #WC. 14. RACE — American Indian, Black, White, etc. Specify: Black 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. MARITAL STATUS 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 166. KIND OF BUSINESS/INDUSTRY 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most) y/Secondary (0-12) College (1-4 or 5+) Laborer 000 €a-17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Lillian Wolls MAY BE 19h MAILING ADDRESS (Street and Number 19a. INFORMANT'S NAME (Type/Print) 2 21853 30650 HAMPDEN IAN 20a. METHOD OF DISPOSITION

1 | Surial 2 | Cremetion 3 | Removal from State
4 | Donation 5 | Other (Specify) 200 LOCATION -20b. PLACE AND DATE OF DISPOSITION (Name of Kehobeth 21. SIGNATURE OF POLERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY ANThony E. WALD 30639 Hampoen are 30639 Anne, 110.265 23. PART is Enter the displays, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haar value. List only one cause on each line. Approximate Interval Retween Onset and Death IMMEDIATE CAUSE (Finel disease or condition Tenshot wound of a reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algrificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 XYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL: OTHER: XXYES 2 NO 1 | Inpatient 2X ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 2ad. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 1 Natural 5 Pending Investigation 12:20 AM 1 - YES 8/26/1995 SUBJECT SHOT COMPLETED BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, DAYRNEERS S RAINBOW INN 3 Sulcide 8 Could not be determined 4 M Homicide PRINCESS ANNE. PARKING LOT SOMERSET COUNTY MARYLAND 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to

2 X MEDICAL EXAMINER: On the basis of examination and/or

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

WRIGHT

night MD

MD St. DELEN LAND IN

200. SYMMATURE AND TITLE OF GERTIFIER

DONALD

BE

2

1995

death occured at the time, data and place, and due to the cause(s) and manner se stated

29d, DATE SIONED (Month, Day, Year)

UGUST 26.

29c, LICENSE NUMBER

C.M.E

111 Penn Street, Baltimore, Maryland 21201